Nevada
Health Insurance
Market Study

Prepared for the State of Nevada

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1. Introduction

With the passing of the Patient Protection and Affordable Care Act of 2010 (ACA), states will need to assess the impact of various components of the law on their health insurance markets. States across the nation will have to make key policy decisions such as how to structure their exchanges and whether to merge Individual and Small Group Markets. In addition, provisions of the ACA will drive significant changes to rating and benefit requirements in the insured markets. Public Consulting Group (PCG) has been tasked by the state of Nevada, Department of Health and Human Services for analysis of federal health care reform, and has subsequently subcontracted Gorman Actuarial, LLC (GA) to assess the impact of the ACA on the Nevada insured markets. This report presents preliminary results of this study and the information presented will assist the state of Nevada in preparing for the changes brought on by the ACA.

2. Key Findings

This section outlines key findings from this study. With full implementation of the ACA, and the availability of premium and cost sharing subsidies, there will be a significant drop in the uninsured population, and the Individual Market will increase significantly. New regulations will bring considerable change to the types of benefit plans offered and the way in which rates are developed. As a result, individuals and employer groups may experience premium disruption, both favorably and unfavorably.

- **Nevada currently has more than a half million uninsured residents, with more than half eligible for subsidies in the exchange.**

GA assumes that the total uninsured in Nevada in CY 2010 is 557,000[1]. The ACA will expand Medicaid eligibility to 138% of Federal Poverty Level (FPL), and offer premium and cost sharing subsidies through a new health insurance exchange to those non-Medicaid individuals and families with income below 400% FPL. As described in Section 6.2, approximately 279,000 currently uninsured[2] will be eligible for subsidies in the exchange, with approximately 106,000 newly insured entering the Individual Market.[3]

- **The Individual Market currently has 87,000 members. By 2016[4], this market may grow to approximately 225,000.**

[1] Based on the Current Population Survey (CPS), which is similar to the estimate of 545,000 from the Kaiser Family Foundation which is based on combined CY 2009 and CY2010 CPS data. http://www.statehealthfacts.org/profileind.jsp?ind=126&cat=3&rgn=30

[2] The total number of uninsured includes a portion of non-citizens who are not eligible for subsidies in the exchange. They have been excluded from the enrollment estimates.

[3] Estimates of enrollment and member migration are used for actuarial analyses to understand impacts to overall premium and should not be used for other purposes. These estimates provide directional guidance and are not intended to be precise.

[4] We assume implementation of the ACA begins on 1/1/14. However, we focus our analysis on 2016 to allow for a phase-in period.

In addition to the current Individual Market and those coming from the currently uninsured population, approximately 43,000 members may migrate to the Individual Market from the employer-sponsored group markets, either to receive subsidies through the exchange or because their employer dropped coverage.

- **The combined impact of the higher morbidity of new entrants to the Individual Market and more comprehensive plan design standards could cause premiums to increase on average 11-30% in the Individual Market before taking into account the available premium subsidies and ACA risk mitigation programs.**

GA has estimated that the new entrants to the Individual Market will have morbidity 8% to 26% worse than the current Individual Market risk pool. In addition, premiums in the Individual Market may increase on average 3% due to the new benefit plan standards.

- **New benefit plan standards and cost sharing subsidies will provide more comprehensive coverage to members in the Individual Market. As a result, average premiums may increase 3%.**

Benefit plan designs in the current Individual Market have an estimated average actuarial value of 0.62. 52% of the Individual Market has a plan with an individual medical deductible of greater than or equal to $2,500. In addition, many plans do not provide coverage for standard maternity benefits, and some do not provide behavioral health benefits. The ACA will require benefit plans (inside and outside the exchange) to provide coverage for "essential benefits" including those currently excluded from many plan offerings in the Individual Market. With the exception of the catastrophic plans, most plans will also be required to have a minimum actuarial value[5] of 0.60.

- **The ACA will eliminate or restrict many carrier rating practices currently prevalent in both the Individual and Small Group Markets. As a result, specific individuals and employer groups may experience premium disruptions.**

The ACA will eliminate health underwriting, and the ability to set rates based on gender, group size, and industry both inside and outside the exchange. Age rating will be restricted within a 3-to-1 band for adults. The rating changes will create premium changes as younger, healthier members and groups will generally pay higher premiums compared to premiums in the absence of the ACA, while older, sicker members and groups will pay less compared to premiums in the absence of the ACA.

- **The Individual Market will experience premium volatility in 2014.**

[5] Actuarial value is defined and discussed in Section 5, and provides a measure of benefit plan value.

Premium changes were modeled after the application of premium tax subsidies. The average ranges resulted in increases as high as 78% and decreases as low as 94%. Younger individuals with high incomes may experience the largest premium increases. Low income individuals may experience the largest premium decreases after the application of premium tax subsidies.

3. Market Landscape

3.1. Data Collection

Gorman Actuarial requested and received data from seven carriers in the Individual Market, eight carriers in the Small Group Market and seven carriers in the Large Group 51-100 Market. Table 1 shows the carriers that responded to the data survey in each of the three market segments. Based on an estimate of the entire Nevada health insurance market[6], the carriers that responded to the survey represent approximately 88% of the Individual Market and 87% of the Small Group Market. Two carriers in the Small Group Market did not provide complete data for this market segment; therefore we have detailed data for approximately 70% of the Small Group Market. Carriers that responded to the survey represent nearly 97% of the Large Group Market, so we believe we have received responses that represent virtually the entire Large Group 51-100 Market. However, one carrier accounts for nearly half the membership in the Large Group 51-100 Market, and they were unable to provide detailed data on this market segment. Note that for the Small Group and Large Group 51-100 Markets in particular, given the carriers that responded to the survey, the data is not representative of the Northern Nevada market.

	Carrier Data Responses		
	Individual	Small Group	Large Group 51-100
Aetna Health Inc.		√	√
Aetna Life Insurance Company	√	√	√
Anthem	√	√	√
Coventry Health & Life Insurance Company	√	√	√
Golden Rule	√		
Health Plan of Nevada	√	√	√
Hometown Health			√
Humana	√	√	
Sierra Health & Life Insurance	√	√	√
United Health Care Insurance Company		√	

Table 1 – Carrier Detailed Survey Respondents[7]

[6] NAIC 2010 Supplemental Healthcare Exhibits were used to estimate carrier market share in the Individual, Small Group and Large Group Market.

[7] Anthem includes both Rocky Mountain Hospital & Medical and HMO Colorado. Even though these are two separate legal entities the data was combined for purposes of the survey and this report given the

We generally define carrier as a separate legal entity.[8] For example, we treated Health Plan of Nevada and Sierra Health and Life Insurance Company as two different carriers. Throughout this report we have obscured each carrier's identity so that the data associated with a particular carrier cannot be identified. We use labels such as "Carrier A", "Carrier B", etc. Note that the carrier labels are not consistent throughout the report. This is done intentionally so that a carrier's identity may not be discerned

3.2. Individual Market

As of 12/31/2010 we estimate that there were approximately 87,000 members and 58,000 subscribers in the Individual Market.[9] The membership as of 12/31/2010 and 6/30/2011 within the market is spread across carriers as shown in Table 2. The top three carriers account for approximately 75% of the membership and the top four carriers account for approximately 85% of the membership. There has been little change in the member distribution by carrier from 12/31/2010 to 6/30/2011.

Carrier	Market Distribution as of 12/31/2010	Market Distribution as of 6/30/2011
A	39%	37%
B	19%	20%
C	17%	19%
D	10%	9%
E	9%	8%
F	4%	3%
G	2%	4%
Total	100%	100%

Table 2 – Individual Market Member Distribution by Carrier[10]

Table 3 shows the Individual Market demographics as of 12/31/2010. The market is split almost evenly between males and females. 28% of the market is age 18 or younger while 25% of the market is age 50 or older. Approximately 16% of the Individual Market is between the ages of 19-29, which is the population that will be eligible for the catastrophic plans in CY 2014.[11] This represents approximately 13,500 members. The estimated overall average age is 33.

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relatively small size of HMO Colorado (HMO Colorado is only offered in the Large Group Market and as of the 2010 Supplemental Health Care Exhibits represents 1% of the Large Group Market.)

[8] Ibid.

[9] These numbers have been adjusted to account for the carriers that did not complete the survey.

[10] This distribution is based on the carriers that responded to our survey.

[11] Individuals under 30 years of age or those exempt from the individual mandate because no affordable plan is available to them may purchase a catastrophic plan providing the essential benefits package with a deductible of $5,950 for a single policy ($11,900 for a family policy) and first dollar coverage for at least

Membership Distribution as of 12/31/2010			
Age Band	Females	Males	Total
0-18	14%	15%	28%
19-34	11%	12%	23%
35-49	12%	12%	24%
50+	14%	11%	25%
Total	51%	49%	100%

Table 3 – Individual Market Age/Gender Distribution[12]

As shown in Table 4, as of 12/31/2010, we estimate that 75% of total contracts are individual only policies, and the average family size of family contracts is 3.0.

Contracts as of 12/31/2010	
Individual Contracts:	75%
Family Contracts:	25%
Average Family Size:	3.0

Table 4 – Individual Market Average Family Size

Table 5 shows that the pure loss ratio in CY 2010 for the entire Individual Market is 69%. This has increased slightly from 68% in CY 2009. We define pure loss ratio as the ratio of incurred claims to premium and therefore it does not correspond to the federal MLR definition that HHS will be using for rebate purposes. The table below also shows an incurred claims PMPM (per member per month) for CY 2010 for the Individual Market. We define incurred claims as claims paid for services incurred in CY 2010.

Individual Market Financials		
	CY 2010	CY 2009
Incurred Claims PMPM	$136	$133
Premium PMPM	$199	$197
Pure Loss Ratio	69%	68%

Table 5 – Individual Market Pure Loss Ratio for CY 2010 and CY 2009

Not all carriers were able to provide complete allowed claims data. Allowed claims are defined as incurred claims plus member cost sharing. For the carriers that were able to provide allowed claims data, on average the incurred claims are approximately 66% of allowed claims in the Individual Market. In other words, on average, the member pays 33% of total medical claims. Table 6 shows the pure loss ratio by carrier. As shown,

three primary care visits. These plans will not be required to meet the 0.60 minimum actuarial value standard.

[12] Child only policies are not currently sold in the Nevada Individual Market. Therefore, the population under age 19 should consist of dependents and not policyholders.

pure loss ratios range from 62% to 78% in CY 2010. The federal MLR standard for purposes of calculating rebates is 75% in CY 2011 for the Individual Market.[13]

Carrier	CY 2010 Pure Loss Ratio
A	69%
B	62%
C	78%
D	71%
E	62%
F	62%
Average	**69%**

Table 6 – Individual Market Pure Loss Ratio by Carrier CY 2010[14]

GA also analyzed the distribution of annual allowed claims by member for the Individual Market. Table 7 shows a distribution of medical claims by member and Table 8 shows a distribution of pharmacy claims by member. Approximately 1% of the population accounts for 46% of total medical costs with an estimated average annual cost of $69,000 per member. Approximately 40% of the market did not incur any medical claims in 2010 and 49% of the market did not incur any pharmacy claims in 2010. The average annual medical allowed claims is $1,498 and the average annual pharmacy allowed claims is $338 for a total annual average of $1,835.

CY 2010 Nevada Individual- Medical Claims			
Annual Allowed Dollars	Cumulative % of Claimants	Cumulative % of Dollars	Average Allowed Claims per Claimant
$0	39.9%	0.0%	$0
$1 - $499	73.0%	4.7%	$212
$500 - $999	82.5%	9.2%	$711
$1,000 - $4,999	94.9%	27.8%	$2,243
$5,000 - $9,999	97.6%	40.3%	$7,043
$10,000 - $24,999	99.2%	56.9%	$15,303
$25,000 - $49,999	99.7%	68.1%	$34,810
$50,000 +	100.0%	100.0%	$142,225
Total	**100.0%**	**100.0%**	**$1,498**

Table 7 – Individual Market CY 10 Medical Allowed Claims Distribution[15]

[13] http://doi.state.nv.us/scs/doc/MLRAdj_%205.13.11.PDF
[14] Does not include carriers with less than 12,000 member months in CY 2010.
[15] Does not include carriers who have a large portion of their claims paid as part of a capitated arrangement.

CY 2010 Nevada Individual- Pharmacy Claims			
Annual Allowed Dollars	Cumulative % of Claimants	Cumulative % of Dollars	Average Allowed Claims per Claimant
$0	48.5%	0.0%	$0
$1 - $49	64.5%	1.1%	$22
$50 - $99	71.3%	2.5%	$72
$100 - $499	87.2%	13.9%	$241
$500 - $999	92.6%	25.2%	$713
$1,000 - $4,999	99.0%	64.3%	$2,062
$5,000 +	100.0%	100.0%	$11,674
Total	**100.0%**	**100.0%**	**$338**

Table 8 – Individual Market CY 10 Pharmacy Allowed Claims Distribution[16]

3.3. Small Group Market[17]

As of 12/31/2010 we estimate that there were approximately 105,000 members and 63,000 subscribers in the Small Group Market.[18] The membership as of 12/31/2010 and 6/30/2011 within the market is spread across carriers as shown in Table 9. The top three carriers account for approximately 80% of the membership and the top four carriers account for nearly 90% of the membership. There have been small changes in the member distribution by carrier from 12/31/2010 to 6/30/2011, with some of the smaller carriers gaining market share and some of the larger carriers losing market share.

Carrier	Market Distribution as of 12/31/2010	Market Distribution as of 6/30/2011
A	35%	34%
B	32%	30%
C	13%	10%
D	9%	10%
E	5%	6%
F	3%	4%
G	3%	3%
H	0%	3%
Total	**100%**	**100%**

Table 9 – Small Group Market Member Distribution by Carrier[19]

[16] One carrier was not able to provide pharmacy allowed claims and is therefore excluded from this table.
[17] The data in this section includes associations.
[18] These numbers have been adjusted to account for the carriers that did not complete the survey.
[19] Note that this distribution is based on the carriers that responded to our survey.

Table 10 shows the Small Group Market demographics as of 12/31/2010. The market is split almost evenly between males and females. 23% of the market is age 18 or younger while 24% of the market is age 50 or older. The estimated overall average age is 35, which is slightly older than the Individual Market.

Membership Distribution as of 12/31/2010			
Age Band	**Females**	**Males**	**Total**
0-18	11%	11%	23%
19-34	13%	12%	25%
35-49	14%	14%	28%
50+	12%	12%	24%
Total	49%	51%	100%

Table 10 – Small Group Market Age/Gender Distribution

As shown in Table 11, as of 12/31/2010, we estimate that 70% of total contracts are individual only policies, which is slightly less than the number of individual only policies in the Individual Market. The average family size of family contracts is 3.2 in the Small Group Market, slightly more than the average family size in the Individual Market.

Contracts as of 12/31/2010	
Individual Contracts	70%
Family Contracts	30%
Average Family Size	3.2

Table 11 – Small Group Market Average Family Size

Table 12 shows that the pure loss ratio in CY 2010 for the entire Small Group Market is 77%. This has decreased a few percentage points from 80% in CY 2009. We define pure loss ratio as the ratio of incurred claims to premium and therefore it does not correspond to the federal MLR definition that HHS will be using for rebate purposes. The table below also shows an incurred claims PMPM (per member per month) for CY 2010 for the Small Group Market. We define incurred claims as claims paid for services incurred in CY 2010. The premium includes both the employee and employer contribution portions. The incurred claims PMPM in the Small Group Market is over 70% higher than the incurred claims PMPM in the Individual Market. This is driven in part by the demographics and health status of the Individual Market compared to the Small Group Market, but also to a larger extent the differences in benefit designs between the two market segments. In general, the benefit offerings in the Small Group Market are much richer than in the Individual Market. This will be explored further in Section 5.

Small Group Market Financials		
	CY 2010	CY 2009
Incurred Claims PMPM	$234	$230
Premium PMPM	$305	$289
Pure Loss Ratio	77%	80%

Table 12 – Individual Market Pure Loss Ratio for CY 2010 and CY 2009

Not all carriers were able to provide complete allowed claims data. Allowed claims are defined as incurred claims plus member cost sharing. For the carriers that were able to provide allowed claims data, on average the incurred claims are approximately 77% of allowed claims in the Small Group Market. In other words, on average, the member pays 23% of total medical claims. This compares to the 33% in the Individual Market, demonstrating the difference in cost sharing between the Small Group and Individual Markets.

Table 13 shows the pure loss ratio by carrier. As shown, pure loss ratios range from 62% to 117% in CY 2010. The federal MLR standard for purposes of calculating rebates is 80% in CY 2011 for the Small Group Market.

Carrier	CY 2010 Pure Loss Ratio
A	117%
B	64%
C	62%
D	67%
E	82%
F	76%
G	78%
Average	77%

Table 13 – Small Group Market Pure Loss Ratio by Carrier CY 2010[20]

GA also analyzed the distribution of annual allowed claims by member for the Small Group Market. Table 14 shows medical claims by member and Table 15 shows pharmacy claims by member. Approximately 1% of the population accounts for 39% of total medical costs, with an estimated average annual cost of $84,000 per member. Approximately 36% of the market did not incur any medical claims in 2010 and 41% of the market did not incur any pharmacy claims in 2010. The average annual medical allowed claims is $1,969 and the average annual pharmacy allowed claims is $503 for a total annual average of $2,472. This is significantly higher as compared to the Individual Market allowed annual average of $1,835. This comparison is based on allowed claims, which includes member cost sharing. So while the difference between the total allowed average of $2,472 in the Small Group Market and the total allowed average of $1,835 in the Individual Market is not driven by cost sharing differences, it is driven by utilization, demographics, and health status differences.

[20] Does not include carriers with less than 12,000 member months in CY 2010.

CY 2010 Nevada Small Group- Medical Claims			
Annual Allowed Dollars	Cumulative % of Claimants	Cumulative % of Dollars	Average Allowed Claims per Claimant
$0	35.9%	0.0%	$0
$1 - $499	66.8%	3.3%	$212
$500 - $999	76.9%	6.9%	$704
$1,000 - $4,999	92.2%	24.4%	$2,243
$5,000 - $9,999	96.2%	38.6%	$6,999
$10,000 - $24,999	98.8%	58.1%	$14,887
$25,000 - $49,999	99.5%	70.5%	$34,393
$50,000 +	100.0%	100.0%	$123,687
Total	**100.0%**	**100.0%**	**$1,969**

Table 14 – Small Group Market CY 10 Medical Allowed Claims Distribution[21]

CY 2010 Nevada Small Group- Pharmacy Claims			
Annual Allowed Dollars	Cumulative % of Claimants	Cumulative % of Dollars	Average Allowed Claims per Claimant
$0	40.6%	0.0%	$0
$1 - $49	56.8%	0.7%	$22
$50 - $99	64.0%	1.7%	$71
$100 - $499	82.3%	10.6%	$245
$500 - $999	88.9%	20.0%	$707
$1,000 - $4,99	98.2%	59.1%	$2,119
$5,000 +	100.0%	100.0%	$11,562
Total	**100.0%**	**100.0%**	**$503**

Table 15 – Small Group Market CY 10 Pharmacy Allowed Claims Distribution[22]

[21] Does not include carriers who have a large portion of their claims paid as part of a capitated arrangement.
[22] One carrier was not able to provide pharmacy allowed claims and is therefore excluded from this table.

3.4. Large Group 51-100 Market

As of 12/31/2010 we estimate that there were approximately 66,000 members and 38,000 subscribers in the Large Group 51-100 Market.[23] The membership as of 12/31/2010 and 6/30/2011 within the market is spread across carriers as shown in Table 16. The top three carriers account for approximately 88% of the membership. Carrier A did not provide a complete data survey and therefore is not included in some of the subsequent tables and analyses.[24] In places where their data was not available, this is noted. There have been some changes in the member distribution by carrier from 12/31/2010 to 6/30/2011, with two carriers in particular gaining some market share and one carrier losing some market share.

Carrier	Market Distribution as of 12/31/2010	Market Distribution as of 6/30/2011
A	51%	53%
B	24%	23%
C	13%	10%
D	6%	8%
E	4%	4%
F	1%	1%
G	1%	1%
H	0%	1%
Total	100%	100%

Table 16 – Large Group 51-100 Market Member Distribution by Carrier[25]

Table 17 shows the Large Group 51-100 demographics as of 12/31/2010. The market has slightly more females. 24% of the market is age 18 or younger while 27% of the market is age 50 or older. The estimated overall average age is 35, similar to the Small Group Market.

Membership Distribution as of 12/31/2010			
Age Band	Females	Males	Total
0-18	12%	12%	24%
19-34	12%	10%	22%
35-49	14%	13%	28%
50+	14%	13%	27%
Total	52%	48%	100%

Table 17 – Large Group 51-100 Market Age/Gender Distribution[26]

[23] These numbers have been adjusted to account for the carriers that did not complete the survey.
[24] While GA recognizes that this carrier represents a large portion of the Large Group 51-100 segment, we have chosen to include the data when possible.
[25] Note that this distribution is based on the carriers that responded to our survey.

As shown in Table 18, as of 12/31/2010, we estimate that 63% of total contracts are individual only policies, and the average family size of family contracts is 3.0.

Contracts as of 12/31/2010	
Individual Contracts	63%
Family Contracts	37%
Average Family Size	3.0

Table 18 – Large Group 51-100 Market Average Family Size[27]

Table 19 shows that the pure loss ratio in CY 2010 for the Large Group 51-100 Market is 78%.[28] This is consistent with the pure loss ratio in CY 2009. We define pure loss ratio as the ratio of incurred claims to premium and therefore it does not correspond to the federal MLR definition that HHS will be using for rebate purposes. In CY 2010 the Large Group 51-100 Market incurred claims PMPM is 2.6% lower than the Small Group Market and the premium PMPM is 3.9% lower. The differences may be due to slight morbidity or plan design differences.

Large Group 51-100 Market Financials		
	CY 2010	CY 2009
Incurred Claims PMPM	$228	$223
Premium PMPM	$293	$285
Pure Loss Ratio	78%	78%

Table 19 – Large Group 51-100 Market Pure Loss Ratio for CY 2010 and CY 2009[29]

Table 20 shows that the pure loss ratio in CY 2010 for the entire Large Group Fully Insured Market is 81%. The overall incurred claims PMPM and premium PMPM for the entire Large Group Fully Insured Market are lower than the 51-100 portion of this market while the overall pure loss ratio is three percentage points higher. The 51-100 portion of the Large Group Market represents approximately 18% of the number of members in the entire Large Group Fully Insured Market. The Large Group 51-100 incurred claims and premium are 9% and 13% higher than the incurred claims and premium in the entire Large Group Market respectively. Note that while we requested information on the Large Group self-insured markets in Nevada for both the 51-100 segment and the entire Large Group segment, carriers either stated that they did not have any self-insured business or declined to provide this information.

[26] Carrier A from Table 16 is included in this data.
[27] Ibid.
[28] Carrier A from Table 16 is not included as their financial information was not provided.
[29] Ibid.

Large Group Market Financials	
	CY 2010
Incurred Claims PMPM	$210
Premium PMPM	$260
Pure Loss Ratio	81%

Table 20 – Large Group 51+ Market Pure Loss Ratio for CY 2010

Table 21 shows the pure loss ratio by carrier for both the Large Group 51-100 segment and the entire 51+ segment. As shown, the pure loss ratios are within a close range for the 51-100 segment, ranging from 75% to 78% in CY 2010. In the 51+ segment, pure loss ratios vary between 74% and 91%. Note that there are more data points in this segment due to the increased credibility of this segment.

Carrier	Large Group 51-100 CY 2010 Pure Loss Ratio	Large Group 51+ CY 2010 Pure Loss Ratio
A	74%	74%
B	n/a	86%
C	78%	82%
D	75%	75%
E	n/a	91%
F	77%	83%
Average	**78%**	**81%**

Table 21 – Large Group Market Pure Loss Ratio by Carrier CY 2010[30,31]

3.5. Comparison of Market Segments

Table 22 provides an overview of the Nevada health insurance market in 2010. This is based on information from the carrier survey data and publicly available information from the Kaiser Family Foundation State Health Facts for the nonelderly population in the state of Nevada.[32,33] In total, there is an estimated 2.3 million nonelderly residents in Nevada in 2010, of which 23% are uninsured, 15% are covered by public programs, 37% are in self-insured arrangements, and the remaining 24% or 557,000 members are in the fully insured commercial market. On a national basis, 18% of the nonelderly population is uninsured and 20% are covered by public programs.[34]

[30] Does not include carriers with less than 12,000 member months in CY 2010.
[31] Carrier A from Table 16 is not included as their financial information was not provided.
[32] http://www.statehealthfacts.org/profileind.jsp?ind=126&cat=3&rgn=30
[33] The estimate of self-insured is based on the difference between the total employer count from the Kaiser Family Foundation less the insured population as estimated from the carrier survey data and the NAIC Supplemental Health Care Exhibits. The total of other public insurance is based on the estimate from the Kaiser Family Foundation along with the difference between the individual counts from the Kaiser Family Foundation and the carrier survey data.
[34] http://www.statehealthfacts.org/profileind.jsp?ind=126&cat=3&rgn=30

2010 Percent and Number of Nonelderly Nevada Residents Insured by Coverage Type		
	Estimated Number	**% of Grand Total**
Fully Insured Commercial Markets		
Individual	87,000	4%
Small Group (2-50)	105,000	5%
Large Group (51+)	365,000	16%
Total Fully Insured	**557,000**	**24%**
Self-Insured Markets		
Large Group (51+)	**854,000**	**37%**
Public Programs		
Medicaid	241,000	10%
Other	113,600	5%
Total Public	**354,600**	**15%**
Uninsured	**557,000**	**24%**
Grand Total	**2,322,000**	**100%**

Table 22 – Nonelderly Health Insurance Market Overview 2010

Figure 1 depicts the member distribution in the Nevada fully insured markets as of 12/31/2010. Overall, the Large Group represents 66% of the fully insured markets, while the Individual and Small Group Markets represent 15% and 19% respectively. The Large Group 51-100 segment accounts for 12% of the total fully insured market (or 18% of the entire Large Group Market) while the Large Group 100+ segment accounts for 54% of the total market (or the remaining 82% of the Large Group Market.)

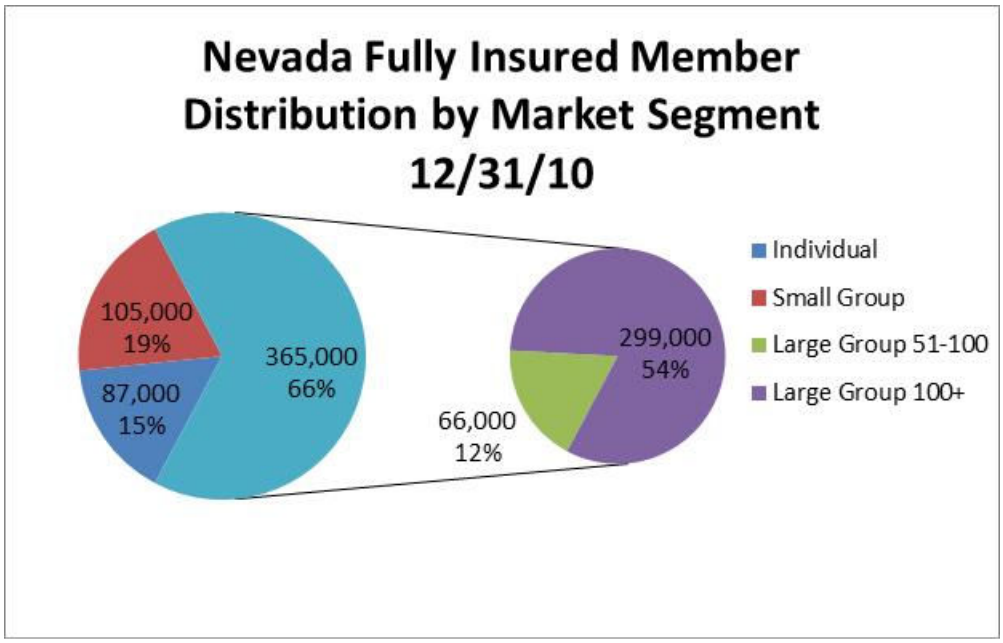

Figure 1 – Fully Insured Member Distribution by Market Segment 12/31/2010

When we examine just the portion of the market represented by individuals and employer groups with less than 100 employees, 34% of the members are in the Individual Market, 41% of the members are in the Small Group Market and the remaining 25% are in the Large Group 51-100 Market segment as of 12/31/2010. This is depicted in Figure 2.

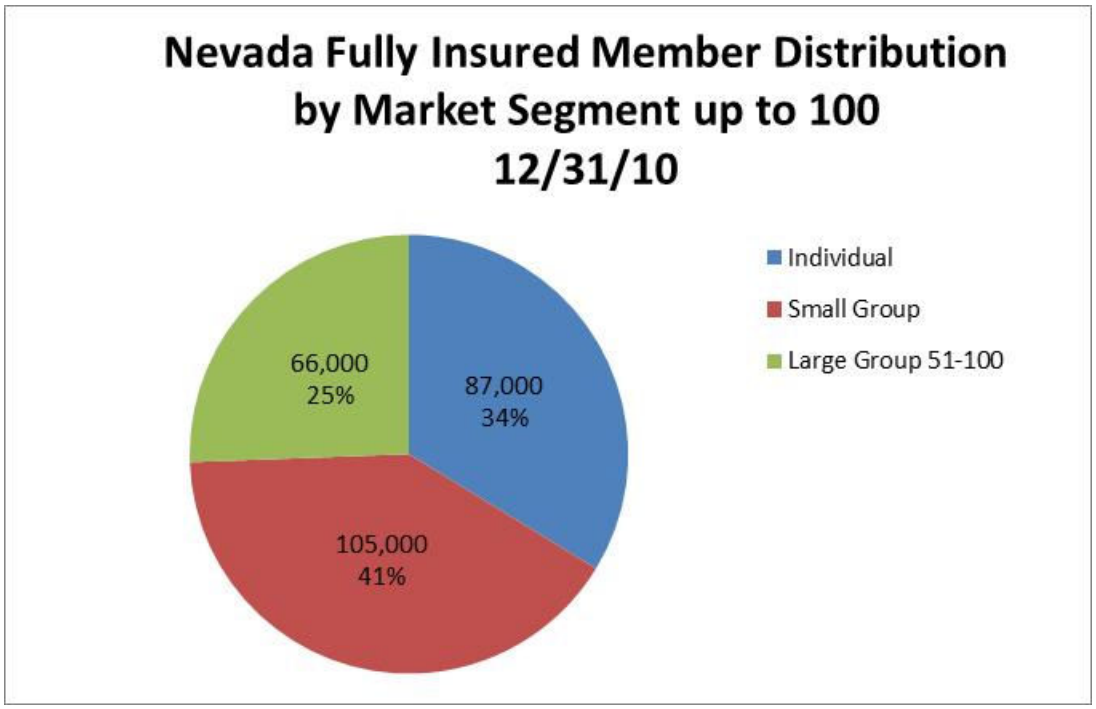

Figure 2 – Fully Insured Member Distribution up to 100 by Market Segment 12/31/2010

Table 23 compares the age demographics for the Individual, Small Group and Large Group 51-100 Market segments. The Individual Market is, on average, two years younger than the other market segments, which is driven by a larger percentage of members of ages 0-18 and a smaller percentage of members of ages 35-49.

Membership Distribution as of 12/31/2010			
Age Band	**Individual**	**Small Group**	**Large Group 51-100**
0-18	28%	23%	24%
19-34	23%	25%	22%
35-49	24%	28%	28%
50+	25%	24%	27%
Estimated Average Age	**33**	**35**	**35**

Table 23 – Demographic Distribution by Market Segment 12/31/2010[35]

Figure 3 compares the incurred claims PMPM and pure loss ratio in CY 2010 for the four market segments: Individual, Small Group, Large Group 51-100 and Large Group 100+. The pure loss ratio (the ratio of incurred claims to premium) for CY 2010 is 69% in the Individual Market compared to 77% in the Small Group Market and 78% in the Large Group 51-100 Market.[36] The incurred claims PMPM in the Small Group and Large Group 51-100 Markets are higher than the Individual Market by approximately 70%. As stated previously, this is driven in part by the demographics and health status of the Individual Market compared to the employer group markets, but also to a larger extent the differences in benefit designs between the market segments.

[35] Carrier A from Table 16 is included in this data.
[36] Carrier A from Table 16 is not included in the Large Group 51-100 pure loss ratio as their financial information was not provided.

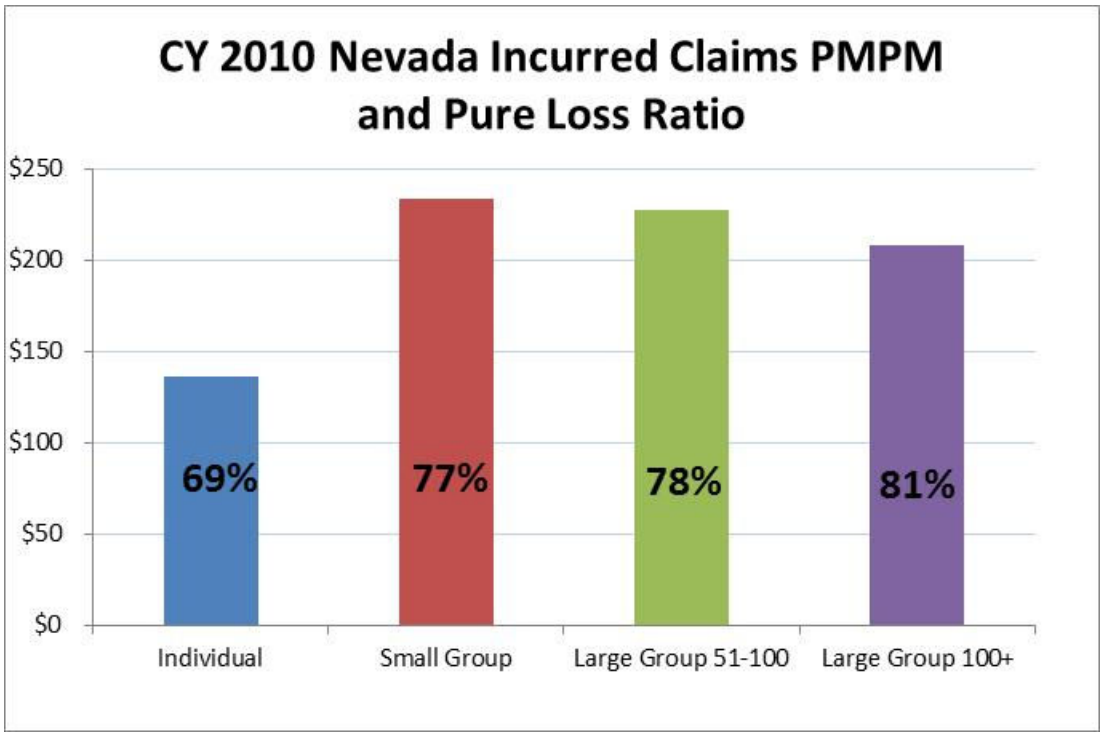

Figure 3 – Incurred Claims PMPM and Pure Loss Ratio by Market Segment[37]

4. Carrier Rating Practices

4.1. Individual Market Rating Practices

The carriers in Nevada generally use similar rating characteristics, as shown in Table 24. The few exceptions are that all but one carrier uses geography as a rating variable, only some carriers use exclusionary riders and only some carriers use spousal or family discounts.

Nevada Individual Market Rating Practices by Carrier						
Carrier	Age/Gender	Tobacco	Geography	Health Underwriting	Exclusionary Riders	Spousal or Family Discount
A	Yes	Yes	Yes	Yes	Yes	Yes
B	Yes	Yes	Yes	Yes	No	No
C	Yes	Yes	Yes	Yes	No	No
D	Yes	Yes	Yes	Yes	No	Yes
E	Yes	Yes	No	Yes	Yes	Yes
F	Yes	Yes	Yes	Yes	No	No
G	Yes	Yes	Yes	Yes	No	No

Table 24 – Individual Market Carrier Rating Practices

[37] Ibid.

In Table 25 we highlight some of the areas of significant reforms to the Individual Market rating environment, and compares Nevada's currently allowed rating practices to the ACA standards in CY 2014.

Nevada Individual Market Rating Practices		
	Nevada Current-Individual	**ACA CY 2014**
Age & Gender	Age & Gender Allowed-No Limit	Age Only- 3 to 1 Band for Adults
Tobacco	Allowed as part of Health Underwriting	Allowed- up to 50%
Geography	Allowed- Regions Defined by Carriers	Allowed- Regions Defined by State
Health Underwriting	Allowed- Limit of 1.75 to 1	Not Allowed
Exclusionary Riders	Allowed	Not Allowed
Duration	Not Allowed	Not Allowed
Spousal or Family Discounts	Allowed	Not Allowed
Guaranteed Issue	No	Yes

Table 25 – Individual Market Carrier Current Rating Practices vs. ACA

Most carriers indicated that for their open blocks when rating a family policy, they rate each member within the family individually and then aggregate the individual rates to determine the overall family rate. Some carriers also indicated that they cap the number of dependent children when determining a family rate at three. Other carriers develop rates for a family policy based on the age and gender of the subscriber (policyholder) and the appropriate tier (e.g. single, dual, subscriber and child(ren) or family). While there is variation in the rating formulas by carrier, the primary methodology involves starting with a member base rate and then adjusting for the various rating factors, the most significant of which are described below, in addition to adjusting for trend and the benefit plan design attributes, which may also include a network factor adjustment.

Age/Gender Rating

All carriers in the Individual Market currently use age and gender rating when setting premiums. Some carriers rate based on the member's age and gender while other carriers rate based on the subscriber's age, gender and rating tier (e.g. single, dual, subscriber and child(ren) or family.) The majority of carriers use age/gender factors that vary for each age while only a few carriers in the Individual Market group multiple ages into age bands (e.g. 25-29) when differentiating age/gender factors. The age/gender curves also vary by carrier as do the age/gender rating bands. The rating bands are calculated by dividing the

maximum age/gender rating factor by the minimum age/gender factor.[38] The age/gender rating bands are shown in Table 26 for adults up to age 64. The highest overall age/gender band is 7.6. We interpret this as the highest rate an insurer charges can be 7.6 times the lowest rate due to age and gender. The lowest overall age/gender band is 3.9, with an overall average of 5.0.

Carrier	Age/Gender Band
A	4.2
B	5.4
C	4.6
D	4.4
E	7.6
F	3.9
Average	5.0

Table 26 – Individual Market Age/Gender Rating Band[39]

Figure 4 shows the male age/gender factors by age category for each carrier listed in Table 26. This graph demonstrates not only the variability by overall rating band, but also the variability of rating factors at different age categories by carrier.

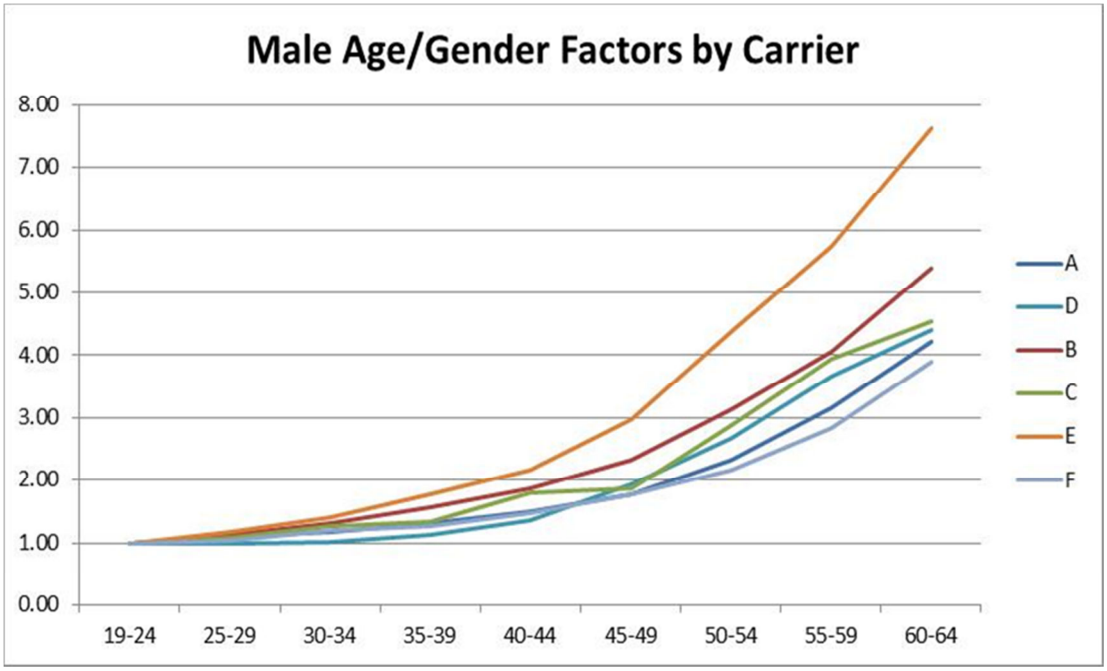

Figure 4 – Individual Market Age/Gender Factors for Males by Carrier[40]

[38] Rating bands were calculated based on rating factors provided by the carriers and factors are grouped into the following age categories: 19-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59 and 60-64. In cases where the rating factors varied by product, averages across all products were calculated.
[39] Only six carriers are shown in this table because two of the carriers use the same age/gender factors.

Some carriers have age/gender curves that vary by different cost sharing attributes, such as the deductible, coinsurance or copay. Figure 5 demonstrates the varying age curve for males from one representative carrier by deductible level. As expected, as age increases, the age adjustment or surcharge increases. However, as the deductible level increases, the age curve becomes steeper. The age adjustment in a $500 deductible plan for a 60-64 year old is approximately 3.4 times the age adjustment for a 0-18 year old while the age adjustment in a $5,000 deductible plan for a 60-64 year old is approximately 4.9 times the age adjustment for a 0-18 year old. This means that an older demographic gets surcharged more in a higher deductible plan as compared to a lower deductible plan. It is unclear if varying age curves by benefit design will be allowed under the ACA.

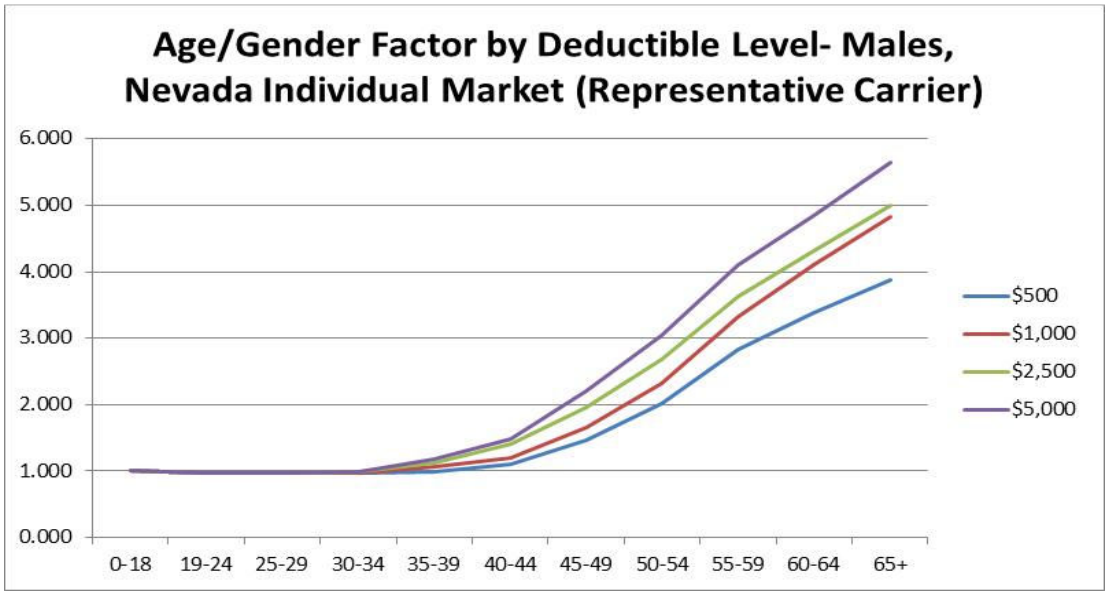

Figure 5 – Individual Market Age/Gender Curve by Deductible Level

Some carriers not only vary age/gender adjustments by benefit design but they also vary age/gender adjustments by contract type, e.g. single and family. It is also unclear if varying age curves by contract type will be allowed under the ACA in CY 2014.

In addition to varying rates by age, all carriers in the Individual Market also vary rates by gender. The ACA does not permit gender rating starting in 2014. Table 27 shows the average difference between female and male rates by different age categories for carriers that rate based on a member's age and gender. Although the degree varies by carrier, rates for females are often higher than males of the same age at ages below 55. At ages above 55, male rates tend to be higher than female rates. In the Individual Market, there is considerable variation between the male and female age factors, in particular for ages between 25 and 39 where the female factor is on average over 30% higher than the male factor at the same age. It should be noted that in the Individual Market, the vast majority

[40] Only six carriers are shown in this table because one set of carriers use the same age/gender factors. The factors for each carrier have been normalized to the average factor for 19-24 year olds, which is generally the minimum average rating factor in this market segment.

of members do not have maternity coverage, but the cost of newborns and complications related to maternity is covered.

Member Age Band	Minimum Difference of Gender Factors by Age Category (Female/Male)	Maximum Difference of Gender Factors by Age Category (Female/Male)	Average Difference of Gender Factors by Age Category (Female/Male)
19-24	17.5%	35.1%	24.2%
25-29	22.9%	45.9%	31.9%
30-34	28.3%	43.0%	35.4%
35-39	25.2%	49.7%	33.6%
40-44	20.9%	46.7%	29.6%
45-49	10.9%	23.0%	16.4%
50-54	-4.4%	10.1%	1.8%
55-59	-12.8%	-2.3%	-7.0%
60-64	-24.4%	-7.4%	-17.2%

Table 27 – Individual Market Age Factor Differences Female vs. Male

Geography Rating

All carriers except one currently vary rates based on geography within the state of Nevada in the Individual Market. The number of rating regions varies between two and four and the average rating band for geography rating factors is 1.2-to-1. That is, the highest rate is 20% higher than the lowest rate due to geography, on average. The regions are typically defined based on counties.

Table 28 depicts the grouping of counties by carrier for purposes of rating by geography in the current Individual Market. Some carriers group Clark and Nye together and the grouping of other counties varies by carrier. Starting in 2014, the ACA will continue to allow rating by geographic region, but the state, rather than each individual carrier, will be required to define the allowable rating regions for all carriers to use.

County Groupings by Carrier						
County	A	B	C	D	E	F
Carson City	4	3	2	2	2	3
Churchill	3	3	3	2	2	2
Clark	1	1	1	1	1	1
Douglas	4	3	3	2	2	2
Elko	3	3	3	2	2	2
Esmeralda	3	2	3	2	1	2
Eureka	3	3	3	2	2	2
Humboldt	3	3	3	2	2	2
Lander	3	3	3	2	2	2
Lincoln	3	3	3	2	1	2
Lyon	4	2	3	2	2	2
Mineral	4	2	3	2	2	2
Nye- Northern	1	2	3	1	1	2
Nye- Southern	1	1	3	1	1	1
Pershing	3	3	3	2	2	2
Storey	4	3	3	2	2	2
Washoe	2	2	2	2	2	2
White Pine	3	3	3	2	2	2

Table 28 – Individual Market County Groupings by Carrier[41]

Table 29 shows the minimum, maximum and average geography rating adjustments for two areas in Nevada along with the geography rating adjustments for all other areas. Each carrier varies which counties are included in each of these areas, but the information below gives a general sense of how the rating adjustments vary by geographic region. There is a large difference in how carriers rate the Las Vegas and Reno areas given the difference between the minimums and maximums, but on average the Las Vegas area receives a slight surcharge, the Reno area receives a slight discount and other areas in Nevada receive a surcharge.

	Geography Rating Adjustments		
	Minimum	Maximum	Average
Las Vegas Area	-1%	14%	2%
Reno Area	-10%	19%	-4%
Other	20%	22%	22%

Table 29 – Individual Market Geography Rating Adjustments[42,43]

Health Underwriting

In the Individual Market, all surveyed carriers use a form of health underwriting. The practice varies among carriers, but the general methodology is that carriers will require

[41] If a carrier has counties that are not included in their service area, these counties are grouped into a region.
[42] The average in this table is based on an approximated weighted average using membership as weights.
[43] The minimum and maximum rating factors excludes areas with no membership.

those seeking health insurance to complete a health questionnaire. Carriers use the information on the questionnaire along with claims data (if available) to assess whether to offer or deny a person coverage. The carrier's reported that between 10% and 25% of new business applicants were denied coverage each month in CY 2010. If a person is not denied coverage, the carrier will use the information to determine how much to discount or surcharge the premium based on their evaluation of a person's relative claims risk compared to others with a similar demographic profile. Some carriers also take into account the use of certain medications or a member's BMI (body mass index) to determine the applicable discount or surcharge. Members are typically grouped into tiers based on the carrier's health underwriting criteria with a specific discount or surcharge assigned to each tier. Some carriers reported using exclusionary riders as a form of health underwriting. This is the practice of excluding certain benefits for a specific pre-existing condition or type of service. The common exclusions in the Individual Market are musculoskeletal disorders, asthma, allergies, breast augmentation and headaches.

Currently, the Nevada statues state that in the Individual Market, if a carrier uses health status as a rating factor, then the highest factor may not exceed the lowest factor by more than 75%.[44] This limitation includes any adjustments for tobacco use. In addition, rating characteristics must not include durational rating, or adverse changes in health or claim experience after a policy is issued. All carriers confirmed that their health status adjustments factors comply with the 1.75 rating band, with most carriers employing the full width of the rating band and other carriers employing something slightly less than the 1.75 rating band.

Table 30 displays the average health underwriting adjustments used in the Individual Market based on the survey data for all carriers. 80% of members received a discount with an average discount of 5%, while 20% of members received a surcharge with an average surcharge of 19%. The average age of members who received a premium discount as a result of health underwriting is nine years younger than those members who received a premium surcharge as a result of health underwriting.

Health Underwriting Adjustments			
	% of Members	Average Rating Adjustment	Average Age
Members Receiving Discount	80%	-5%	31
Members Receiving Surcharge	20%	19%	40

Table 30 – Individual Market Health Underwriting Adjustments[45]

Starting in 2014, for non-grandfathered business, the ACA will disallow any use of health status in determining a person's eligibility for insurance or the premium rates charged both inside and outside of the exchange. Thus, the use of health questionnaires, medical

[44] Nevada Revised Statutes, NRS 689A.680.
[45] The average in this table is a weighted average using member months as weights.

history, claims history, disability status, pre-existing condition exclusions and genetic testing will be excluded in premium rate development. In addition, carriers will not be allowed to deny coverage.

All of the carriers surveyed in the Individual Market use tobacco use as part of their health underwriting. Only some carriers were able to segregate the impact of tobacco use from their overall health status assessment. Of the carriers that were able to report on their tobacco surcharge, the overall average surcharge currently used in the market is 20%, with a maximum surcharge of 50% and a minimum surcharge of 10%. Approximately 4% of members are reported as tobacco users for these carriers.

Starting in 2014, the ACA will continue to allow tobacco use as a rating variable with a maximum allowable surcharge of 50% compared to rates for non-users of tobacco. With the elimination of health underwriting in 2014, carriers will be unable to assess and charge different rates based on a member's health status. Therefore it may be possible that carriers will consider utilizing tobacco rating as their only allowable indicator of health status and raise tobacco surcharges in cases where the surcharge is not already at the allowable maximum of 50%.

Spousal or Family Adjustment

Some of the carriers in the Individual Market use a spousal or family discount. For carriers that use spousal discounts, the discounts range from 8% to 10% and it impacts approximately 13% of members. In the case of a family discount, discounts of approximately 5% are given to families with 2 or more members. We believe that starting in CY 2014, carriers will no longer be allowed to apply these types of discount for non-grandfathered business.

4.2. Small Group Market Rating Practices[46]

The current definition of Small Group Market in Nevada is defined as two to fifty eligible employees. In CY 2014 and CY 2015, the state has the option to define Small Group as up to 50 employees or up to 100 employees, with the definition moving up to 100 employees in CY 2016. The carriers in the Small Group Market generally use similar rating characteristics compared to each other, as shown in Table 31. The one exception is that some carriers do not use geography rating.

[46] For the purposes of this report, GA has tried to include the Association segment within the Small Group Market. However, for this section, GA has not reported on Association rating practices.

Nevada Small Group Market Rating Practices by Carrier						
Carrier	Age/Gender	Geography	Health Underwriting	Group Size	Industry	List Bill Part of Market
A	Yes	Yes	Yes	Yes	Yes	Yes
B	Yes	Yes	Yes	Yes	Yes	No
C	Yes	Yes	Yes	Yes	Yes	Yes
D	Yes	No	Yes	Yes	Yes	Yes
E	Yes	Yes	Yes	Yes	Yes	Yes
F	Yes	Yes	Yes	Yes	Yes	Yes
G	Yes	No	Yes	Yes	Yes	Yes
H	Yes	Yes	Yes	Yes	Yes	No

Table 31 – Small Group Market Rating Practices

In addition, we captured which carriers list bill part of their market. All but two carriers indicated that they list bill part of their market and, for the majority of carriers, it is the groups with two to nine employees that are list billed. List billing is a method of calculating premiums for each subscriber or member by taking all demographic characteristics into consideration. This contrasts to a group composite premium calculation, where the demographic characteristics of all subscribers or members within an employer group are averaged. Generally, when carriers list bill, premiums will reflect real time enrollment each month. For group composite premiums, premium rates are fixed until the next anniversary of the group. While list billing is more accurate and mitigates rate shock for an employer, it is also more complex to administer.

Table 32 highlights some of the areas of significant reform to the Small Group Market rating environment, and compares the currently allowed Nevada practices to the ACA standards in 2014.

Nevada Small Group Market Rating Practices		
	Nevada Current- Small Group	ACA CY 2014
Age & Gender	Age & Gender Allowed- No Limit	Age Only- 3 to 1 Band for Adults
Tobacco	Allowed as part of Health Underwriting	Allowed- up to 50%
Geography	Allowed- Regions Defined by Carriers	Allowed- Regions Defined by State
Health Underwriting	Allowed- Limit of 1.857 to 1	Not Allowed
Group Size	Allowed	Not Allowed
Industry	Allowed- Limit of 1.2 to 1	Not Allowed

Table 32 – Small Group Market Rating Practices vs. ACA

Premium rates in the Individual Market are set at the member or subscriber level. In employer group markets rates are established for each employer group. With the exception of groups that are list billed, premiums are generally calculated using the average demographics of the group. Premiums are developed based on rating tiers and there is variation among the carriers as to the tier structure offered. Most carriers offer a four tier structure which typically means each group has a rate for employee only, employee with a child or children, couple and family coverage. Two tier, three tier and five tier rate structures are also offered by some carriers in this market.

Age/Gender Rating

All carriers in the Small Group Market currently use age and gender rating when setting premiums. Similar to what was found in the Individual Market, some carriers rate based on the member's age and gender while other carriers rate based on the subscriber's age, gender and rating tier (e.g. employee only, employee with a child or children, couple and family.) The majority of carriers in the Small Group Market group multiple ages into age bands (e.g. 25-29) when differentiating age/gender factors. The age/gender curves also vary by carrier as do the rating bands. The rating bands are calculated by dividing the maximum age/gender rating factor by the minimum age/gender factor.[47] The age/gender rating bands are shown in Table 33 for adults up to age 64. The highest overall age/gender band is 6.7. That is, the highest rate charged is 6.7 times the lowest rate charged due to age and gender. The lowest overall age/gender band is 4.4, with an overall average of 5.6. The overall average rating band in the Small Group Market is slightly higher compared to that in the Individual Market while the amount of variation among the rating bands by carriers in the Small Group Market is slightly less compared to the variation of rating bands in the Individual Market.

Carrier	Age/Gender Band
A	6.7
B	6.2
C	4.8
D	4.4
E	6.1
F	5.5
Average	5.6

Table 33 – Small Group Market Age/Gender Bands

Figure 6 shows the male age/gender factors by age category for each carrier listed in Table 33. This graph demonstrates not only the variability by overall rating band, but also the variability of rating factors at different age categories by carrier.

[47] Rating bands were calculated based on rating factors provided by the carriers and factors are grouped into the following age categories: 19-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59 and 60-64.

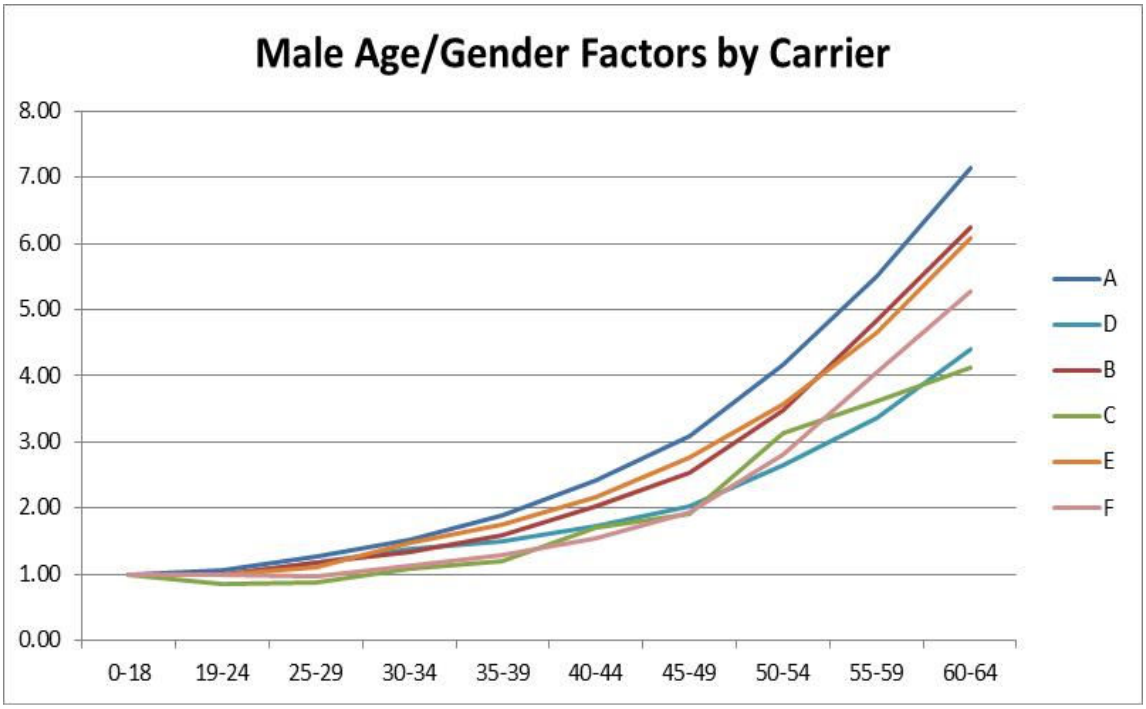

Figure 6 – Small Group Market Age/Gender Factors for Males by Carrier[48]

In addition to varying rates by age, all carriers in the Small Group Market also vary rates by gender. Table 34 shows the average difference between female and male rates by different age categories for carriers that rate based on a subscriber's age and gender. These differences are for employee only rates. Although the degree varies by carrier, rates for females are often higher than males of the same age at ages below 55. At ages above 55, male rates tend to be higher than female rates. There is a large difference between the minimum and maximum differences for ages below 40 signifying significant variation among the carriers within the Small Group Market. Also note that the variation in gender differences is even higher compared to the differences shown in Table 27 in the Individual Market for ages below 40. One reason for this may be that in the Individual Market maternity benefits (not including complications resulting from maternity) are not covered for the vast majority of members, while in the Small Group Market the vast majority of members do have maternity benefits, therefore driving some of the larger difference between female and male rating factors below age 40 in the Small Group Market. Starting in 2014, gender rating will be eliminated per the ACA.

[48] Only six carriers are shown in this table because two sets of carriers use the same age/gender factors. The factors for each carrier have been normalized to the average factor for 19-24 year olds, which is generally the minimum average rating factor in this market segment.

Subscriber Age Category	Minimum Difference of Gender Factors by Age Category (Female/Male)	Maximum Difference of Gender Factors by Age Category (Female/Male)	Average Difference of Gender Factors by Age Category (Female/Male)
19-24	53.3%	120.4%	90.2%
25-29	32.7%	163.8%	95.1%
30-34	20.7%	140.0%	75.2%
35-39	15.6%	82.5%	50.1%
40-44	12.1%	46.6%	29.9%
45-49	7.3%	26.1%	16.9%
50-54	-4.1%	11.6%	3.7%
55-59	-11.5%	0.1%	-6.0%
60-64	-15.5%	-9.0%	-12.3%

Table 34 – Small Group Market Age Factor Differences Female vs. Male

It does not appear that carriers in the Small Group Market vary their age/gender factors by product as was found in the Individual Market.

Geography Rating

All but two carriers currently vary rates based on geography within the state of Nevada. The number of rating regions varies between two and four and the average rating band for geography rating factors is 1.7-to-1. That is, the highest rate is 70% higher than the lowest rate due to geography, on average. It is interesting to note that by removing the carrier with the highest rating band the average rating band for geography rating factors decreases to 1.3-to-1. The regions are typically defined based on counties. Table 35 depicts the grouping of counties by carrier for purposes for rating by geography in the current Small Group Market. Most carriers group counties near Las Vegas and counties near Reno into separate regions, but there is variation as to exactly which counties are grouped into each of these regions. Starting in 2014, the ACA will continue to allow rating by geographic region, but the state, rather than each individual carrier, will be required to define the allowable rating regions for all carriers to use.

County Groupings by Carrier						
County	A	B	C	D	E	F
Carson City	4	2	3	3	3	2
Churchill	3	3	2	3	3	3
Clark	1	1	1	1	1	1
Douglas	4	2	2	3	3	2
Elko	3	3	2	3	3	3
Esmeralda	2	3	2	3	2	3
Eureka	2	3	2	3	3	3
Humboldt	2	3	2	3	3	3
Lander	2	3	2	3	3	3
Lincoln	1	3	2	3	3	3
Lyon	4	3	2	3	2	2
Mineral	3	3	2	3	2	3
Nye- Northern	1	3	2	3	2	3
Nye- Southern	1	3	1	3	1	1
Pershing	3	3	2	3	3	3
Storey	4	2	2	3	3	2
Washoe	4	2	2	2	2	2
White Pine	2	3	2	3	3	3

Table 35 – Small Group Market County Groupings by Carrier[49]

Table 36 shows the minimum, maximum and average geography rating adjustments for two areas in Nevada along with the geography rating adjustments for all other areas. Each carrier varies which counties are included in each of these areas, but the information below gives a general sense of how the rating adjustments vary by geographic region. There is a large difference in how carriers rate each of these areas given the difference between the minimums and maximums, but overall the Las Vegas area receives a slight discount, the Reno area receives a surcharge and other areas in Nevada are more largely surcharged.[50]

	Geography Rating Adjustments		
	Minimum	Maximum	Average
Las Vegas Area	-7%	3%	-2%
Reno Area	-7%	20%	6%
Other	22%	50%	23%

Table 36 – Small Group Market Geography Rating Adjustments[51,52]

Health Underwriting

[49] If a carrier has counties that are not included in their service area, these counties are grouped into a region.
[50] Note again that for the Small Group Market in particular, given the carriers that responded to the survey, the data is not representative of the Northern Nevada market.
[51] The average in this table is based on an approximated weighted average using membership as weights.
[52] The minimum and maximum rating factors excludes areas with no membership.

In the current Small Group Market, health underwriting is permitted for the purpose of developing a premium rate. Small Group regulations currently allow carriers to vary rates +/- 30% around an index rate (1.857-to-1 rate band) for groups with similar characteristics.[53] In the Small Group Market, all surveyed carriers use a form of health underwriting. The practice varies among carriers, but the general methodology is that carriers will require those seeking health insurance to complete a health questionnaire. Some carriers have a longer health questionnaire for groups with fewer employees.

Table 37 shows the average health underwriting adjustments used in the Small Group Market based on the survey data for all carriers. 62% of members received a discount with an average discount of 12%, while 38% of members received a surcharge with an average surcharge of 21%. The average age of members who received a premium discount as a result of health underwriting is two years younger than those members who received a premium surcharge as a result of health underwriting.

Health Underwriting Adjustments				
	% of Members	% of Groups	Average Rating Adjustment	Average Age
Members Receiving Discount	62%	60%	-12%	34
Members Receiving Surcharge	38%	40%	21%	36

Table 37 – Small Group Market Health Underwriting Adjustments[54]

Some carriers take tobacco use into consideration within the health underwriting process. In 2014, when other types of underwriting based on health status are eliminated, tobacco use will remain as an allowable rating surcharge, up to 50%. Although there are operational challenges, Small Group carriers may make greater efforts to reliably collect that information to use it as an indicator of relative health status for group plans.

Group Size Rating

Current Small Group regulations in Nevada allow group size as a rating factor. The average rating band for group size is 1.3-to-1. That is, the highest rate is 30% greater than the lowest rate due to group size on average. The smallest rating band is 1.1-to-1 and the largest rating band is 1.5-to-1.

Table 38 shows the minimum, maximum and average rating adjustments by group size for the Small Group Market.[55] The rating adjustment for group size decreases as the group size increases. The smallest groups receive an average surcharge of 11% while the largest groups receive an average discount of 9%. Note that the groups with less than 6

[53] Nevada Revised Statutes, NRS 689C.230.
[54] The average in this table is a weighted average using member months as weights.
[55] Most carriers defined group sizes within the Small Group Market based on the number of enrolled employees.

employees are also on average 4 years older than groups with 6 or more employees. The ACA does not allow group size as a rating factor starting in 2014.

Group Size Adjustment						
Group Size	% of Members	% of Groups	Minimum Rating Adjustment	Maximum Rating Adjustment	Average Rating Adjustment	Average Age
less than 6	30%	69%	3%	23%	11%	38
6 to 9	18%	15%	-3%	2%	-1%	34
10 to 15	16%	8%	-7%	-1%	-4%	34
16 to 24	16%	5%	-8%	-1%	-5%	34
25 to 50	20%	4%	-13%	-1%	-9%	34

Table 38 – Small Group Market Group Size Adjustment[56]

The data also shows that group size adjustments vary among micro-groups, or groups less than 6. In the Small Group Market, some carriers set premium rates for groups of sizes 2 and 3 that are 10% to 30% more than groups of size 4 and 5.

Industry Rating

Current Small Group regulations in Nevada allow carriers to differentiate rates by the type of industry a group is in. The rating factors are typically based on the primary SIC classification. The regulations allow carriers to vary industry rating factors by as much as 20% for different classes of business.[57] In practice, all carriers vary rates based on industry and all but one carrier employs the maximum rating variation allowed. Starting in 2014, carriers will no longer be allowed to use industry adjustments as a rating factor.

4.3. Large Group 51-100 Market Rating Practices

As expected, the rating formula for the 51-100 Market is generally more complex than the Individual and Small Group Markets and there is considerably more variation among carriers. Table 39 shows the different rating adjustments used by carriers in the Large Group 51-100 Market. While all carriers use age/gender and industry rating adjustments, there is variation as to which carriers use rating adjustments for attributes such as geography, health underwriting and group size.

[56] The average in this table is a weighted average using member months as weights.
[57] Nevada Revised Statutes, NRS 689C.240.

Nevada Large Group Market 51-100 Rating Practices by Carrier					
Carrier	Age/Gender	Geography	Health Underwriting	Group Size	Industry
A	Yes	No	Yes	Yes	Yes
B	Yes	Yes	No	Yes	Yes
C	Yes	Yes	Yes	Yes	Yes
D	Yes	No	Yes	Yes	Yes
E	Yes	Yes	No	Yes	Yes
F	Yes	Yes	Yes	No	Yes
G	Yes	Yes	Yes	No	Yes

Table 39 – Large Group 51-100 Market Rating Practice[58]

In addition, there is variation as to which carriers use an experience rating formula to set premiums. An experience rating formula uses the actual claims experience of an employer group to establish premium rates. The claims experience is generally blended with a "manual" rate that is adjusted for various rating factors such as those listed in Table 39. Carriers will blend the experience rate and the manual rate using credibility weights. The greater the group size, the greater the credibility of the group's experience, and therefore more weight is given to the group's experience. The credibility tables may vary among carriers. Three out of the seven carriers surveyed experience rate as part of their Large Group 51-100 rating formula and we estimate that these carrier's represent approximately one-third of the Large Group 51-100 Market. The remaining two-thirds of the Large Group 51-100 Market uses a formula that adjusts a manual rate by various rating factors, similar to what is done in the Small Group Market.[59]

When the 51-100 Market is merged with the Small Group Market starting in either CY 2014 or CY 2016[60], carriers will no longer be allowed to experience rate this market segment. The only adjustments that will be allowed are age, tobacco use and geography.

5. Private Market Benefit Plan Analysis

Gorman Actuarial requested and received data from carriers in the Individual Market, Small Group Market and Large Group 51-100 Market.[61] Based on an estimate of the entire Nevada health insurance market[62], the carriers that responded to the survey represent approximately 88% of the Individual Market and 87% of the Small Group Market. Carriers that responded to the survey represent nearly 97% of the Large Group Market, so we believe we have received responses that represent virtually the entire Large Group 51-100 Market. Benefit plan design information was requested to represent

[58] Carrier A from Table 16 is not included as their rating information was not provided.
[59] Ibid.
[60] Note that the state has the option to define Small Group as 1-50 prior to CY 2016.
[61] One carrier was able to provide benefit design information for the Small and Large Group 51-100 Markets, but did not provide detailed data for these market segments.
[62] NAIC 2010 Supplemental Healthcare Exhibits were used to estimate carrier market share in the Individual, Small Group and Large Group Market.

85% of the carrier's membership in the Individual and Small Group Markets, and the top 10 benefit plans in the Large Group 51-100 Market. We estimate that we received benefit design information that represent 90%, 81% and 54% of the membership of the surveyed carriers in the Individual, Small Group and Large Group 51-100 Markets, respectively.

5.1. Private Market Benefit Plan Analysis

In Section 3, it was noted that the Individual Market had lower average premiums and claims as compared to the Small Group Market. A driver of the lower costs is the differences in benefit plans purchased within each market. In order to understand the value of the benefits purchased, we have calculated an actuarial value for members within the Individual, Small Group and Large Group 51-100 Markets. Actuarial value is defined in simple terms as the share of medical costs covered by the health plan. The higher the actuarial value, the more comprehensive, or the richer, the benefit plan design. The lower the actuarial value, the more the member pays for benefits and member cost sharing. For the same benefit plan design, there can be significant variation in estimated actuarial value due to a variation in the assumptions used to calculate them. Actuarial value models use data such as claims distributions and utilization data. The underlying data of a model may vary across geographies due to cost differences as well as different practice patterns. Actuarial value calculations may also vary from one carrier to another within the same state. The U. S. Department of Health and Human Services (HHS) has issued a bulletin that suggests that states will be required to use a federal calculator to calculate actuarial value.[63] In addition, the bulletin suggests that states may petition to use their own claims distribution data rather than the national data to support the calculations in the federal calculator. The federal calculator will focus on the primary cost sharing elements that impact actuarial value. For these reasons, the actuarial values we show in this report will most likely be different than what will eventually be used in determining the "metal tiers" (bronze, silver, gold or platinum). However, we believe the information provided in this section can be used to provide directional guidance. In addition, the analysis performed here may assist the state in determining whether they would like to use state specific data or national data once the federal calculator is developed and released.

Gorman Actuarial received benefit plan design details and membership information from carriers with the greatest market share in the Individual, Small Group and Large Group 51-100 Markets. Using this data, Gorman Actuarial developed high level average actuarial value estimates for each market segment. Gorman Actuarial calibrated its actuarial value model using Nevada specific data. Our modeling of actuarial value accounts for many benefit plan design attributes, including the presence or absence of:

- Included benefits (preventive services with no member cost sharing)
- Excluded benefits, such as maternity coverage, mental health and substance abuse coverage

[63] http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf

- Member cost sharing levels, such as copay and coinsurance amounts for primary care and specialist office visits, outpatient day surgery, emergency room and inpatient hospitalizations
- Medical deductible and coinsurance
- Out-of-pocket maximums
- Pharmacy coverage
    - Pharmacy deductible
    - Pharmacy coinsurance
    - Pharmacy out-of-pocket maximums
    - Pharmacy copays for retail generic, brand formulary and brand non-formulary drugs

Figure 7 shows the estimated average actuarial value for the Individual, Small Group and Large Group 51-100 Markets. The average actuarial value in the Individual Market is 0.62. This suggests that on average the carriers pay for 62% of medical expenses while members pay for 38% of medical expenses. The average actuarial value of the Small Group Market is 0.75 and the Large Group 51-100 Market is 0.79. There is a large difference between the benefit plan design for the average Individual Market member as compared to the Small Group Market and Large Group 51-100 Market member. This is common nationwide. Additionally, it is common for larger employers to have more comprehensive plan designs as compared to smaller employers. Individual purchasers are the most price sensitive and therefore each year tend to "buy down" to less comprehensive products to counteract premium increases that they experience.

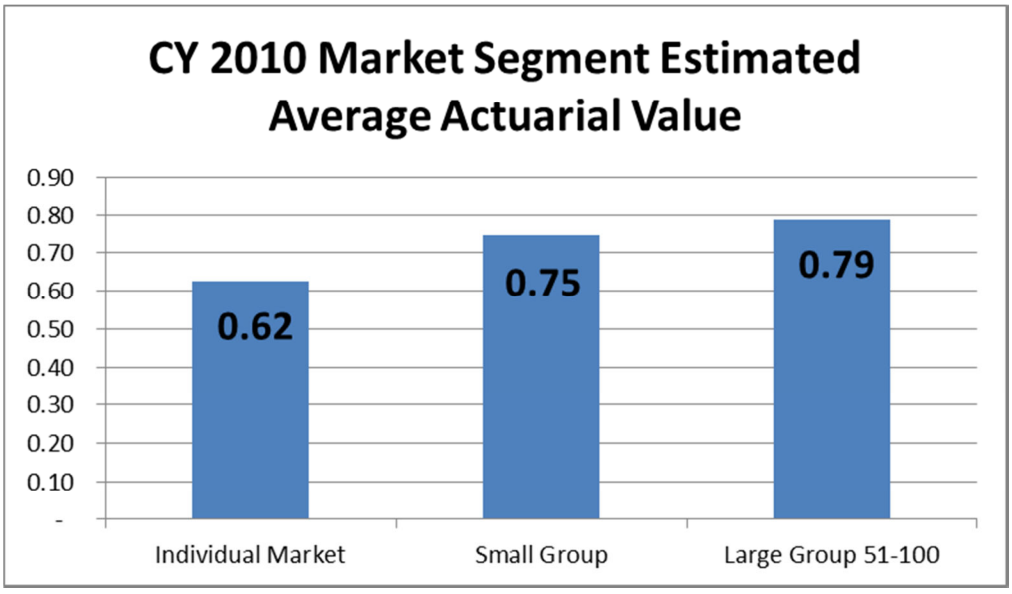

Figure 7 – Estimated Average Actuarial Value by Market Segment

The distribution of estimated actuarial value shows that the Individual Market has more members in benefit plans that have lower actuarial values and therefore higher member cost sharing, as shown in Figure 8. This will be discussed in more detail for each of the market segments.

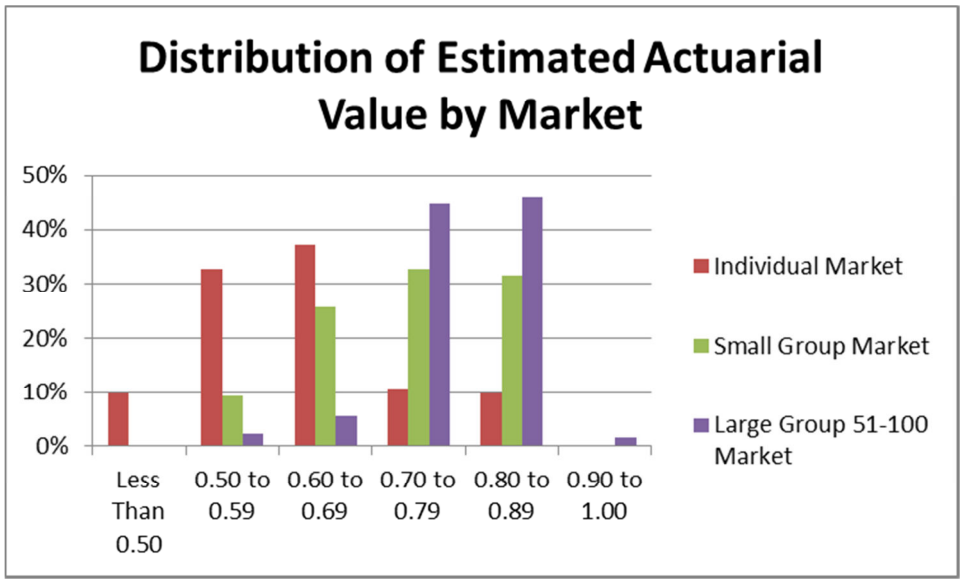

Figure 8 – Distribution of Estimated Actuarial Value by Market Segment

In addition to actuarial value, we also analyzed the distribution of single policy in-network deductibles, coinsurance and out-of-pocket maximums. A comparison of these benefit plan attributes is provided for the three market segments. Single policy in-network deductibles are much higher in the Individual Market as compared to the Small Group and Large Group 51-100 Markets, as shown in Figure 9. The average deductible in the Individual Market is approximately $2,800 while it is close to $1,000 in the Small and Large Group 51-100 Markets. Note that these averages include those members that have no deductible. Figure 10 shows the distribution of deductibles by market segment, and illustrates that a much higher percentage of Individual Market members are in benefit plans with high deductibles (31% with a deductible of $5,000 or greater in the Individual Market compared to approximately 2% in the Small Group and Large Group 51-100 Markets).

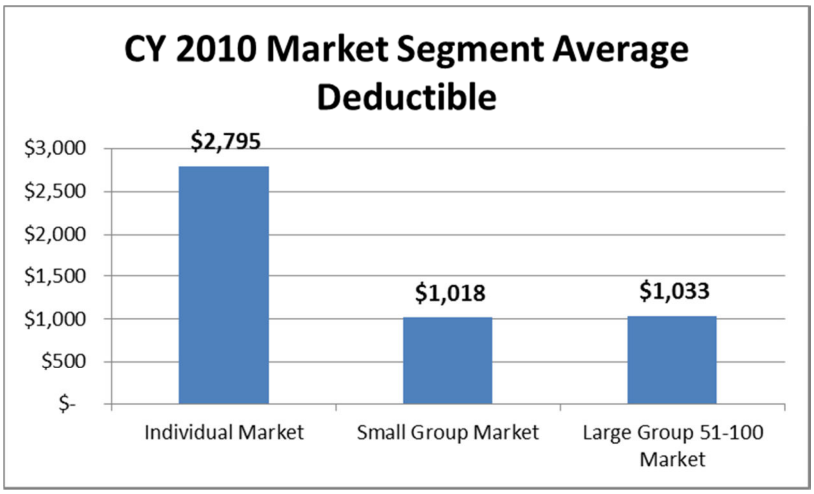

Figure 9 – Average Single Policy In-network Deductible by Market Segment

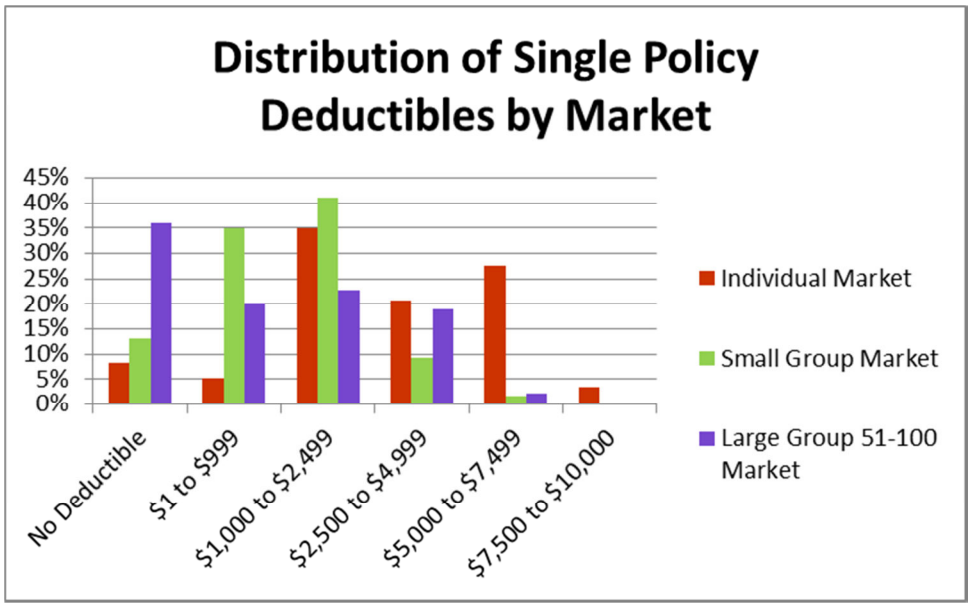

Figure 10 – Distribution of Single Policy In-network Deductible by Market Segment

Members with benefit plans that have coinsurance represent about three quarters of the Individual and Small Group Markets and one third of the Large Group 51-100 Market, as shown in Table 40. In the Individual Market, for members with benefit plans that have coinsurance, the average coinsurance is 76%, which is the coinsurance percentage paid by the carrier. The distribution of coinsurance in each of the three markets is shown in Figure 11. The distribution of coinsurance is very similar in the Individual and Small Group Markets. This contrasts with the Large Group 51-100 Market which is skewed towards higher employer coinsurance charges.

Market	Percent of Members with Coinsurance	Avg Coinsurance for those with Coinsurance
Individual Market	76%	76%
Small Group Market	75%	75%
Large Group 51-100 Market	32%	77%
Total	67%	76%

Table 40 – Average Employer Coinsurance by Market Segment

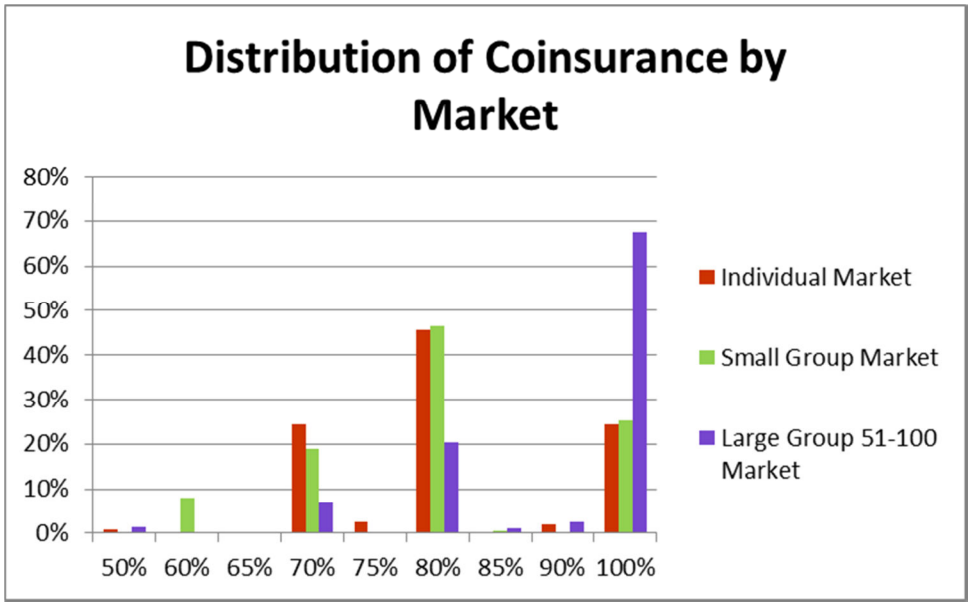

Figure 11 – Coinsurance Distribution by Market Segment

On average, members in the Individual Market have higher single policy out-of-pocket maximums as compared to the Small and Large Group 51-100 Markets, as shown in Figure 12. Note that these averages exclude the small percentage of members in the Small and Large Group 51-100 Markets that have no out-of-pocket maximums. The distribution of out-of-pocket maximums in each of the three markets is shown in Figure 13, and illustrates that Individual Market members are more likely to have higher out-of-pocket maximums.

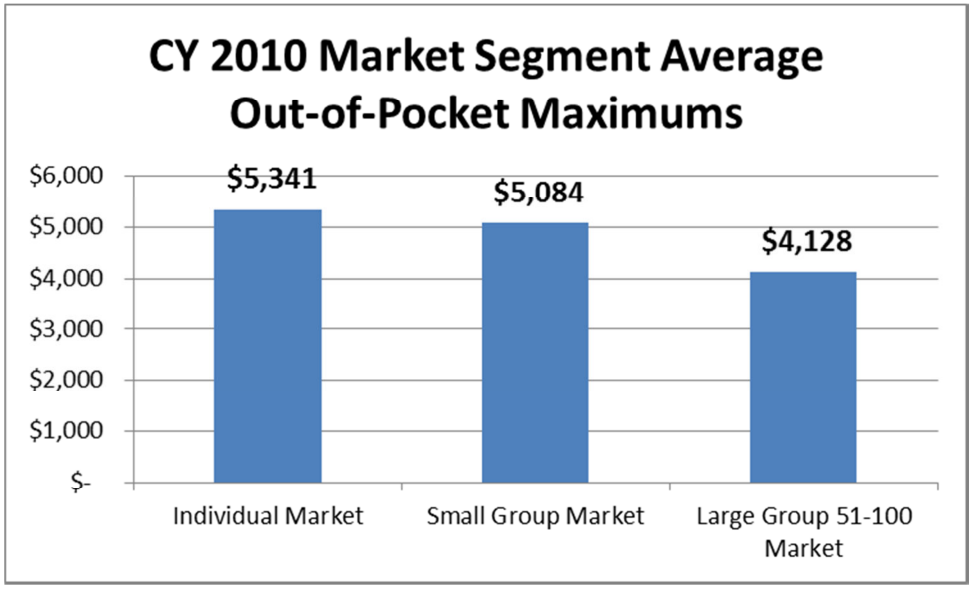

Figure 12 – Average Single Policy Out-of-Pocket Maximums by Market Segment

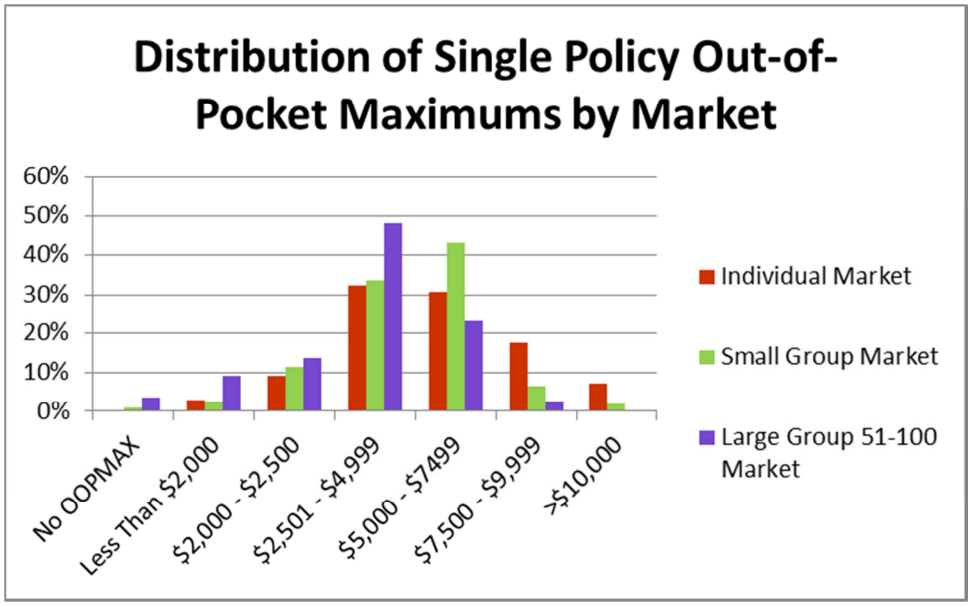

Figure 13 – Distribution of Single Policy Out-of-Pocket Maximums by Market Segment

Actuarial value also depends on whether or not the benefit plan provides a pharmacy benefit and, if it does, the richness of the pharmacy benefit. In the Nevada market, 91% of members in the Individual Market and virtually all members in the Small and Large Group 51-100 Markets have a pharmacy benefit. The presence of a separate pharmacy deductible will also influence the actuarial value of the benefit plan. Table 41 shows the prevalence of benefit plans that have a pharmacy deductible that is integrated with the medical deductible.

Market	Percent of Membership with an Integrated Pharmacy Deductible
Individual Market	10.3%
Small Group Market	4.3%
Large Group 51-100 Market	6.9%
Total	7.1%

Table 41 – Prevalence of Integrated Medical and Pharmacy Deductibles

In the Small Group and Large Group 51-100 Markets, while a small portion of members (4% and 7%, respectively) have an integrated deductible, virtually all other members have benefit plans that do not have a separate pharmacy deductible. In the Individual Market 16% of members that do not have an integrated deductible have a separate pharmacy deductible, and the distribution is shown in Table 42.

Pharmacy Deductible	Percent of Membership
$ 100	1%
$ 150	7%
$ 200	2%
$ 250	1%
$ 500	4%
$ 1,000	0%
$ 7,500	2%
None	84%
Total	**100%**

Table 42 – Distribution of Pharmacy Deductibles in Individual Market[64]

5.2. Individual Market

Figure 14 shows the estimated distribution of deductibles for members in the Individual Market based on the carrier survey responses. For consistency, it is based only on the single policy deductible from each member's benefit plan even if the member has family coverage and a potentially higher family deductible.

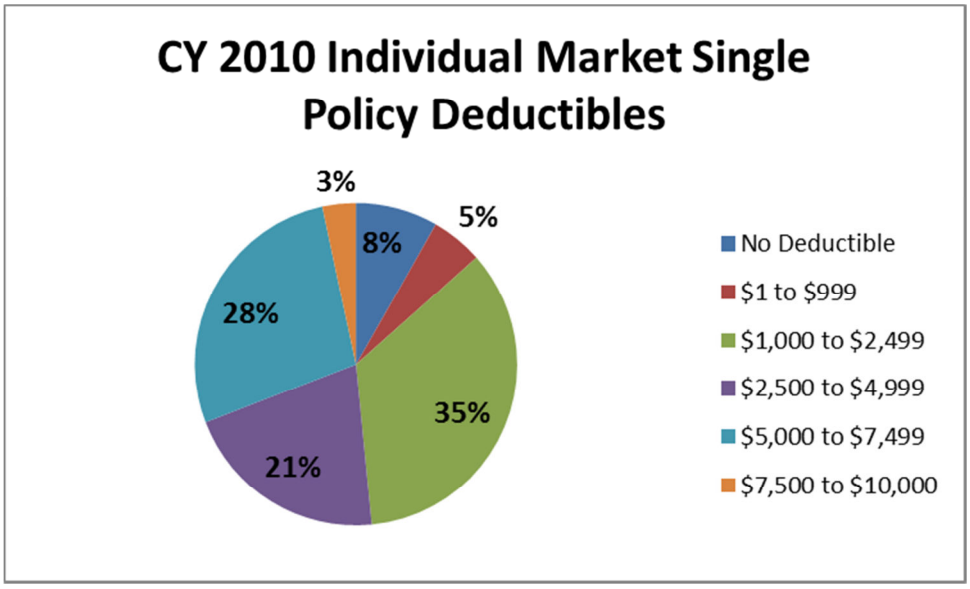

Figure 14 – Individual Market Distribution of Single Policy Deductible

In its purest form, a $1,000 deductible means that the member must cover 100% of the first $1,000 of medical claims before the carrier covers any portion of claims above that. All non-grandfathered benefit plans will have exceptions for certain services, such as preventive care, to be covered immediately without applying the deductible, which is

[64] Approximately 2% of members are in benefit plans that have a $7,500 pharmacy deductible that applies only to specialty drugs.

often referred to as "first dollar" coverage. Other benefit plans offered in the Nevada market combine deductibles for some services and copayments for others. The deductibles shown may apply to all services or a subset of services, depending on the particular benefit plan. In the Individual Market, approximately 13% of the members are in benefit plans with deductibles less than $1,000. 52% of the market is enrolled in a benefit plan with a deductible greater than or equal to $2,500.

High deductible levels can be most impactful in reducing the actuarial value of a benefit plan, but other cost sharing has an impact as well. Once the deductible has been satisfied, a benefit plan can require members to pay for a portion of the additional costs until a member's out-of-pocket maximum is reached. This additional share of costs is called "coinsurance". In the Individual Market, approximately two-thirds of enrolled members have a coinsurance beyond the deductible. For those benefit plans that require coinsurance, the average member coinsurance share is 24%. This means that members will pay 24% of costs above the deductible until they have reached the out-of-pocket maximum. The carrier will then pay 100% of the costs for covered benefits.

The Individual Market single policy out-of-pocket maximum (OOPMAX) distribution is shown in Table 43. The out-of-pocket maximum is the maximum liability a member will pay out-of-pocket. For example, an out-of-pocket maximum of $10,000 means that a member will pay at most $10,000 out of their pocket in a year. Table 43 illustrates that 25% of the Individual Market has an out-of-pocket maximum greater than or equal to $7,500.

Out of Pocket Maximum Range	Membership
No OOPMAX	0%
Less Than $2,000	3%
$2,000 - $2,500	9%
$2,501 - $4,999	32%
$5,000 - $7499	31%
$7,500 - $9,999	18%
>$10,000	7%
All	**100%**
Average OOPMAX	**$ 5,341**

Table 43 – Individual Market Single Policy Out-of-Pocket Maximum Distribution

In CY 2014, products offered in the Individual Market will be classified into four product categories: Platinum, Gold, Silver, and Bronze with corresponding actuarial values of 0.90, 0.80, 0.70, and 0.60. Consumers that are not eligible for cost sharing subsidies have the choice of benefit plans in the various metallic tiers. However, consumers wishing to receive premium tax subsidies and cost sharing subsidies must enroll in a silver plan (0.70 actuarial value) or higher. If these individuals enroll in a gold or platinum plan they

will have to pay the premium difference between the silver premium and the gold/platinum premium, and will not be eligible for cost sharing subsidies. Those individuals who are eligible for cost sharing subsidies and enroll in a silver plan will be placed in "modified silver" plans. For example, households earning between 138% FPL and 150% FPL will be placed in a "modified silver plan" with an actuarial value of 0.94. Households that earn between 150% FPL and 200% FPL will be placed in a plan with an actuarial value of 0.87. Households that earn between 200% FPL and 250% FPL will be placed in a plan with an actuarial value of 0.73. For these members, the out of pocket limits and cost-sharing elements will be reduced as compared to someone purchasing the silver plan with no cost sharing subsidies (actuarial value of 0.70). For illustrative purposes we have grouped the Individual Market members by broad ranges of actuarial value and shown the distribution for the Individual Market in Table 44.

Estimated Actuarial Value Range	Membership
Less Than 0.50	9.7%
0.50 to 0.59	32.8%
0.60 to 0.69	37.2%
0.70 to 0.79	10.4%
0.80 to 0.89	9.9%
Total	100.0%

Table 44 – Individual Market Estimated Actuarial Value Distribution

Beginning in 2014, the ACA will require that all Individual and Small Group benefit plans cover a set of "essential benefits". A recent bulletin[65] released by HHS will require states to define essential benefits by identifying benchmark plans using four criteria:

1. the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
2. any of the largest three State employee health benefit plans by enrollment;
3. any of the largest three national FEHBP plan options by enrollment; or
4. the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

The framework as defined in the law includes maternity care, behavioral health treatment and prescription drugs, among other benefits. We have estimated that 91% of the Individual Market has the pharmacy benefit, and that 42% have no behavioral health or partial behavioral health benefits. Finally, almost 100% of the Individual Market does not have the maternity benefit. The ACA will also require that all benefit plan designs (excluding catastrophic plans[66]) provide benefits at a minimum actuarial value of 0.60

[65] ESSENTIAL HEALTH BENEFITS BULLETIN, Center for Consumer Information and Insurance Oversight, December 16, 2011, Section C, pg. 9 "Four Benchmark Plan Types"

[66] Individuals under 30 years of age or those exempt from the individual mandate because no affordable plan is available to them may purchase a catastrophic plan providing the essential benefits package with a deductible of $5,950 for a single policy ($11,900 for a family policy) and first dollar coverage for at least

("Bronze" level). Member cost sharing will be limited to $5,950 per single policy or $11,900 per family policy. Some individuals will be required to "buy up" to more comprehensive plan designs that meet at least the Bronze standard. We have estimated that 10% of the existing Individual Market would experience premium increases averaging 30% and a third of the market experiencing premium increases averaging a little less than 3%. Overall, the Individual Market may experience a 3% increase due to the minimum actuarial value requirement.

5.3. Small Group Market

On average, benefit plans in the Small Group Market provide more coverage than those in the Individual Market. The estimated average actuarial value of the Small Group Market is 0.75, approximately 20% higher than the estimated actuarial value of the Individual Market.

Figure 15 shows the estimated distribution of single policy deductibles for members in the Small Group Market based on the carrier survey responses. The Small Group Market is enrolled in lower cost sharing products as compared to the Individual Market with 89% of the market enrolled in policies with deductibles less than $2,500, as compared to 48% in the Individual Market.

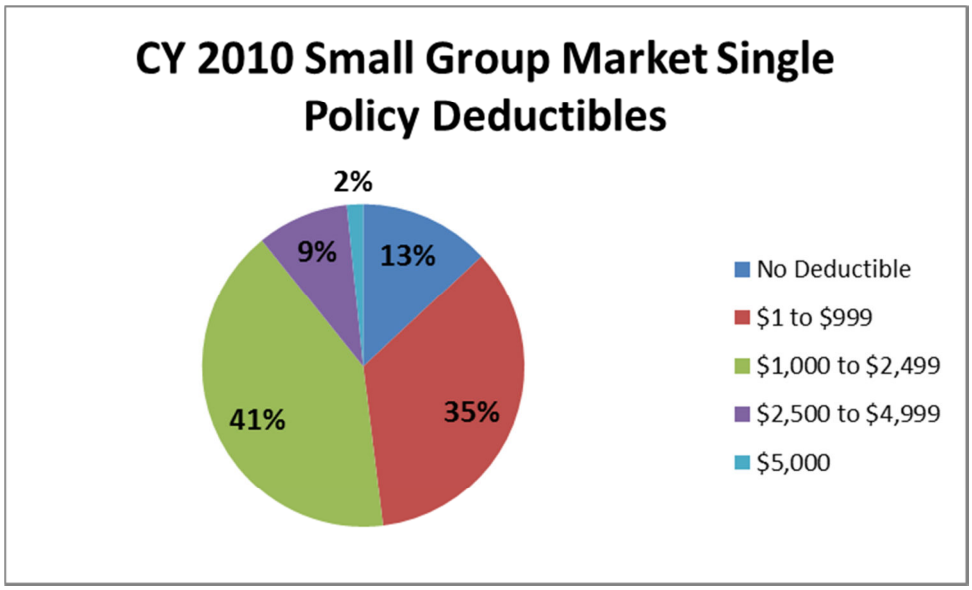

Figure 15 – Small Group Market Distribution of Single Policy Deductible

In addition to the lower deductibles, benefit plans in the Small Group Market are generally more comprehensive in the types of services they cover compared to benefit plans in the Individual Market. Essentially all Small Group benefit plans provide pharmacy, maternity and behavioral health benefits. In 2014, the ACA will limit

three primary care visits. These plans will not be required to meet the 0.60 minimum actuarial value standard. For the purpose of this analysis, we have assumed an actuarial value of 0.45 for the catastrophic plans.

deductibles in the Small Group Market to $2,000 per individual and $4,000 per family. We have estimated that approximately 11% of the Small Group Market is currently enrolled in benefit plans that have greater than a $2,000 deductible[67].

The Small Group Market single policy out-of-pocket maximum (OOPMAX) distribution is shown in Table 45. In contrast with the Individual Market, only 9% (versus 25%) of the Small Group Market has an out-of-pocket maximum greater than or equal to $7,500.

Out of Pocket Maximum Range	Membership
No OOPMAX	1%
Less Than $2,000	3%
$2,000 - $2,500	11%
$2,501 - $4,999	34%
$5,000 - $7499	43%
$7,500 - $9,999	7%
>$10,000	2%
All	**100%**
Average OOPMAX	**$ 5,084**

Table 45 – Small Group Market Out-of-Pocket Maximum Distribution

In CY 2014, products offered in the exchange will be classified into four product categories: Platinum, Gold, Silver, and Bronze with corresponding actuarial values of 0.90, 0.80, 0.70, and 0.60. For illustrative purposes we have grouped the Small Group Market members by broad ranges of actuarial value as shown in Table 46.

Estimated Actuarial Value Range	Membership
0.50 to 0.59	9.4%
0.60 to 0.69	25.8%
0.70 to 0.79	32.8%
0.80 to 0.89	31.7%
0.90 to 1.00	0.3%
Total	100.0%

Table 46 – Small Group Market Estimated Actuarial Value Distribution

Benefit plans will also need to meet the minimum 0.60 "Bronze" actuarial value standard in 2014. Similar to the Individual Market, this will mean that some employer groups in

[67] PPACA Section 1302 Section c, (2) Annual Limitation on Deductibles for Employer-sponsored Plans A) IN GENERAL.— In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed—(i) $2,000 in the case of a plan covering a single individual; and (ii) $4,000 in the case of any other plan.

plans that do not meet the standard will need to "buy up" to a more comprehensive plan. We have estimated that 10% of the Small Group Market may experience an average premium increase of 7% due to the minimum actuarial value requirement or a 0.5% premium increase to the whole Small Group Market.

5.4. Large Group 51-100 Market

The ACA defines the Small Group Market as 1 to 100 eligible employees. However, states have the option to define small group as 1 to 50 employees until CY 2016. The 51-100 Market will experience some premium disruption as they become part of the Small Group Market. Carriers will be required to revise their rating formula to an adjusted community rating environment. This market segment will also need to adhere to the same benefit requirements as the rest of the current Small Group Market.

On average, benefit plans in the Large Group 51-100 Market provide more coverage than those in the Individual Market, and slightly more than those in the Small Group Market. The estimated average actuarial value of the Large Group 51-100 Market is 0.79, approximately 26% higher than the estimated actuarial value of the Individual Market, and 5% higher than the estimated actuarial value of the Small Group Market.

Figure 16 shows the estimated distribution of single policy deductibles for members in the Large Group 51-100 Market based on the carrier survey responses. It is interesting to note that more than a third of members in this market have policies with no deductible. The Large Group 51-100 Market is enrolled in lower cost sharing products as compared to the Individual Market with 79% of the market enrolled in policies with deductibles less than $2,500, as compared to 48% in the Individual Market. While there are more members in this market with no deductible as compared to the Small Group Market (36% compared to 13%) there are also more members at the higher deductible range, specifically in $2,500 and $3,000 deductible plans (6% and 13% compared to 2% and 7%, respectively, in the Small Group Market).

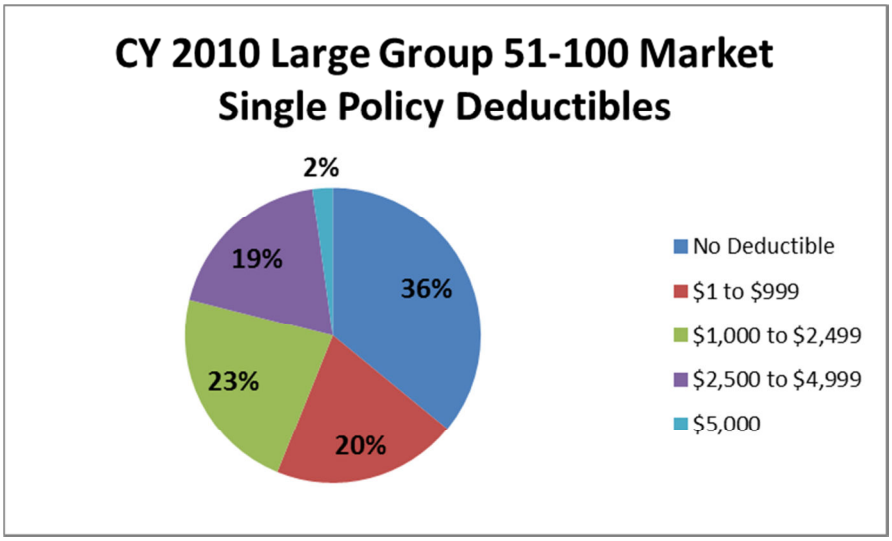

Figure 16 – Large Group 51-100 Market Distribution of Single Policy Deductible

Benefit plans in the Large Group 51-100 Market are similar to benefit plans offered in the Small Group Market and are generally more comprehensive than benefit plans in the Individual Market. Essentially all Large Group 51-100 benefit plans provide pharmacy, maternity and mental health benefits. In 2014, the ACA will limit deductibles in the Small Group Market to $2,000 per individual and $4,000 per family[68]. We have estimated that approximately 21% of the Large Group 51-100 Market is currently enrolled in benefit plans that have greater than a $2,000 deductible[69].

The Large Group 51-100 Market single policy out-of-pocket maximum (OOPMAX) distribution is shown in Table 47. The Large Group 51-100 Market has only 2% of members with out-of-pocket maximums greater than or equal to $7,500.

Out of Pocket Maximum Range	Membership
No OOPMAX	4%
Less Than $2,000	9%
$2,000 - $2,500	14%
$2,501 - $4,999	48%
$5,000 - $7499	23%
$7,500 - $9,999	2%
>$10,000	0%
All	**100%**
Average OOPMAX	**$ 4,128**

Table 47 – Large Group 51-100 Market Out-of-Pocket Maximum Distribution

In CY 2014, products offered in the exchange will be classified into four product categories: Platinum, Gold, Silver, and Bronze with corresponding actuarial values of 0.90, 0.80, 0.70, and 0.60. For illustrative purposes we have grouped the Large Group 51-100 Market members by broad ranges of actuarial value as shown in Table 48.

[68] The definition of Small Group will vary from state to state. For CY 2014 and CY 2015 states have the option of defining Small Group as either up to 50 or up to 100 employees.

[69] PPACA Section 1302 Section c, (2) Annual Limitation on Deductibles for Employer-sponsored Plans A) IN GENERAL.—In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed—(i) $2,000 in the case of a plan covering a single individual; and (ii) $4,000 in the case of any other plan.

Estimated Actuarial Value Range	Membership
0.50 to 0.59	2.2%
0.60 to 0.69	5.5%
0.70 to 0.79	44.8%
0.80 to 0.89	45.9%
0.90 to 1.00	1.6%
Total	100.0%

Table 48 – Large Group 51-100 Market Estimated Actuarial Value Distribution

Benefit plans will also need to meet the minimum 0.60 "Bronze" actuarial value standard in 2014. Similar to the Individual and Small Group Markets, this will mean that some employer groups in benefit plans that do not meet the standard will need to "buy up" to a more comprehensive benefit plan. We have estimated that 1% of the Large Group 51-100 Market may experience a premium increase of 2% due to the minimum actuarial value requirement.

5.5. Summary

On average, the benefit plan designs in the Individual Market are less rich than those in the Small and Large Group 51-100 Markets. Thirty one percent of the Individual Market is enrolled in a $5,000 deductible or greater. Only 2% of the Small Group and Large Group 51-100 Markets are enrolled in a $5,000 deductible. Furthermore, the Individual Market is enrolled in products with higher out-of-pocket member liability than the Small Group and Large Group 51-100 Markets. This difference in market segments is typical and not specific to Nevada. In CY 2014 we would expect to see individual purchasers enrolled in more comprehensive plan designs as compared to the current Individual Market. This is due to a minimum actuarial value requirement of 0.60[70] and an essential benefit requirement which will require some individuals to purchase more comprehensive plan designs. In addition, those individuals who take advantage of the premium and cost sharing subsidies will likely be enrolled in more comprehensive plan designs as compared to the current market. Therefore, the average actuarial value of the Individual Market will most likely increase in CY 2014 (and beyond) under the ACA. Based on our analysis of the current market, it appears that the Individual Market will experience some premium increases due to the essential benefit and minimum actuarial value requirement. The Small Group and Large Group 51-100 Markets may also experience premium increases, but to a lesser extent.

[70] Individuals under 30 years of age or those exempt from the individual mandate because no affordable plan is available to them may purchase a catastrophic plan providing the essential benefits package with a deductible of $5,950 for a single policy ($11,900 for a family policy) and first dollar coverage for at least three primary care visits. These plans will not be required to meet the 0.60 minimum actuarial value standard.

6. ACA Rating Environment Reforms

The ACA will prescribe a number of rating practice reforms that will impact carrier pricing practices and plan premiums in the Individual and Small Group Markets both inside and outside of the exchange. The new provisions will improve affordability for some people, and allow others to gain access to the private markets where they have been denied previously. At the same time, premiums may increase substantially for other individuals in the market.

6.1. Individual Market

Age & Gender – In 2014, the ACA will no longer allow gender to be used as a rating variable both inside and outside of the exchange. Age rating will still be allowed, but the highest adult rate based on age must be no more than three times the lowest adult rate. This is referred to as a 3-to-1 rate band. Current practice for all surveyed carriers in the market (and common across the industry) is to base rates on age and gender. It is therefore useful to study the impacts on a combined basis even though these ACA changes are distinct.

All surveyed carriers currently use an age/gender rating band of greater than 3-to-1, with the average age/gender rating band equal to 5-to-1 as shown in Section 4.1. With the ACA changes required starting in 2014, gender rating will be eliminated and carriers will be required to reduce the overall variance of their maximum and minimum rates to comply with the 3-to-1 age band for adults. Gorman Actuarial has modeled the impact on age and gender cohorts within the current Individual Market. In addition, carriers may increase premiums overall as they expect older individuals to enter the Individual Market and potentially increase the overall morbidity of the market. In this section, we address premium change due to the rating changes. The expected change in risk pool is analyzed separately in Section 6.2. Table 49 shows a summary of the average impact by cohort for the current market population.[71] Overall, the increases and decreases will offset each other and generate no additional premium in total. The impacts do not reflect other rating changes, future healthcare cost trends, or the impact of premium subsidies.

[71] This analysis models the elimination of the ability to gender rate and rescales the age factors to within a 3-to-1 band. The new age factors are then normalized using the Individual Market distributions.

Average Impact of Age/Gender Rating Changes		
Age Category	Females	Males
0-18	-5% to 5%	-5% to 5%
19-24	-5% to -10%	15% to 20%
25-29	-5% to -10%	15% to 20%
30-34	-5% to -10%	20% to 25%
35-39	-5% to -10%	20% to 25%
40-44	-5% to -10%	15% to 20%
45-49	-5% to 5%	10% to 15%
50-54	-5% to 5%	-5% to 5%
55-59	-5% to 5%	-5% to -10%
60+	-5% to 5%	-15% to -20%

Significant Increases (>=15%)
Moderate Increases (5 to 10%)
Minimal Impact (Increase or Decrease < 5%)
Moderate Decreases (5% to 10%)
Significant Decreases (>=15%)

Table 49 – Estimated Individual Market Premium Impact of 2014 ACA Age/Gender Rating Reforms[72]

Each carrier uses different rating factors for different age categories and will still maintain flexibility in setting their specific rating factors by age within the 3-to-1 band for adults, therefore the range of potential premium impacts for each individual member may vary considerably even for those at the same age and gender. Based on our modeling, males between the ages of 30 and 39 will be impacted most unfavorably as they will experience premium increases due to both the elimination of gender rating, and the reduction of the allowable age rating band. Females between the ages of 19 and 44 will experience moderate premium decreases as the positive impact of the gender rating elimination is offset by premium increases based on tighter age bands. Male adults over the age of 55 will experience favorable premium impacts as their rates are reduced to comply with the 3-to-1 band.

Health Underwriting – In the Individual Market, all surveyed carriers are using a form of health underwriting. Currently, the Nevada statues state that in the Individual Market, if a carrier uses health status as a rating factor, then the highest factor may not exceed the lowest factor by more than 75%.[73] This limitation includes any adjustments for tobacco use. In addition, rating characteristics must not include durational rating, or adverse changes in health or claim experience after a policy is issued.

Starting in 2014, ACA will disallow any use of health status in determining a person's eligibility for insurance or the premium rates charged both inside and outside of the exchange. Thus, the use of health questionnaires, medical history, claims history, disability status, pre-existing condition exclusions and genetic testing will be excluded in premium rate development. In addition, carriers will not be allowed to deny coverage. Members that have had premium surcharges due to unfavorable health status underwriting will experience decreases in their rates while members that have received discounted rates due to their preferred health status will likely experience premium increases. Table 50 estimates the premium impact of the elimination of health underwriting. 80% of members are expected to experience an average 5% increase in their premium as a result of this change, while 20% of members are expected to

[72] Based on age and gender of member. Only includes data for carriers that rate using member based age/gender factors. Impacts averaged across carriers and weighted by membership.
[73] Nevada Revised Statutes, NRS 689A.680.

experience an average 16% decrease in their premium as a result of this change. Similar to the age/gender rating changes, the overall increases and decreases are expected to offset each other and generate no change to premiums in total. The average age of those members expected to receive a premium increase is nine years younger than those members expected to receive a premium decrease.

Impact of Elimination of Health Underwriting			
	% of Members	Average Premium Impact	Average Age
Premium Increase	80%	5%	31
Premium Decrease	20%	-16%	40

Table 50 – Estimated Individual Market Premium Impact of Elimination of Health Underwriting

Tobacco – All surveyed carriers in the Individual Market currently surcharge rates for tobacco use. Starting in 2014, ACA will continue to allow tobacco use as a rating variable both inside and outside of the exchange and the maximum surcharge will be 50% compared to rates for non-users of tobacco. As stated in Section 4.1, rate surcharges for most tobacco users appear to be below 50% in the current Individual Market, and as low as 10%. Of the carriers that were able to report on their tobacco surcharge, the overall average surcharge currently used in the market is 20%. With the elimination of health underwriting in 2014, carriers will be unable to assess and charge different rates based on a member's health status. Therefore it may be possible that carriers will consider utilizing tobacco rating as their only allowable indicator of health status and raise tobacco surcharges in cases where the surcharge is not already at the allowable maximum of 50%.

6.2. Individual Market Post ACA

Due to the premium and cost sharing subsidies for low income individuals and the individual mandate, there will be new market entrants in CY 2014 and beyond. We have estimated that the Individual Market will grow from 87,000 to between approximately 210,000 and 265,000 with a best estimate of 225,000 in CY 2016.

GA's analysis is separated into four parts: (1) determining the eligible uninsured (2) estimating the number of uninsured that will take-up insurance through their employer (3) estimating the remaining uninsured that will take-up insurance through the Individual Market and (4) analyzing the new Individual Market risk pool.

(1) Determining the Eligible Uninsured

Our analysis began with reviewing membership estimates for Nevada's uninsured market by age category, income level, and self-reported health status. GA utilized a three year average from the Current Population Survey to determine these estimates. For modeling purposes, GA assumes that the total uninsured in Nevada in CY 2010 is 557,000. In addition, we have adjusted these numbers to account for unauthorized immigrants.[74] We have estimated that 21% of the uninsured are non-citizens with half being unauthorized

[74] Unauthorized immigrants will not be eligible for premium and cost sharing subsidies.

immigrants. This leaves approximately 496,000 uninsured eligible for Medicaid and subsidized insurance through the exchange. It should be noted that Nevada has the highest share of unauthorized immigrants in their population, compared to all other U.S. states. 7.2% of Nevada's population is estimated to be unauthorized immigrants as compared to the national average of 3.7%.[75] Table 51 shows the income distribution for the uninsured after adjusting for unauthorized immigrants. Note that 36% of the population earns less than 138% of the Federal Poverty Level (FPL) and will be eligible for Medicaid and therefore are not eligible for the premium and cost sharing subsidies in the exchange. In addition, GA has assumed that children of households earning between 138% and 200% FPL will enroll into the Nevada Children's Health Insurance Program (CHIP).[76] We have estimated approximately 17,000 children will be eligible for Nevada's CHIP program. Once adjustments are made for unauthorized immigrants and individuals eligible for Medicaid and CHIP, we are left with an estimated 279,000 individuals eligible for premium and cost sharing subsidies in the exchange.

FPL	Income Distribution
<138%	36%
138% to 150%	3%
150% to 200%	14%
200% to 250%	11%
250% to 300%	8%
300% to 350%	6%
350% to 400%	4%
400% +	17%
Total	100%

Table 51 – Income Distribution of Nevada Eligible Uninsured

(2) Uninsured and Employer-Sponsored Insurance

GA has also estimated that a portion of the uninsured population will take-up insurance through employer-sponsored insurance (ESI). From CPS, GA has estimated that approximately 43% of Nevada's eligible uninsured adults earning above 138% FPL are working full time. GA has estimated that 40% of these individuals are offered insurance through their employer and will take-up. This equates to approximately 50,000 previously uninsured individuals taking up insurance through their employer, leaving 229,000 uninsured individuals eligible for subsidies in the exchange.[77] Note that while we assume that there are new entrants into the group market, we also assume that there

[75] http://www.pewhispanic.org/2011/02/01/appendix-a-additional-figures-and-tables , Table A4

[76] http://www.statehealthfacts.org/profileind.jsp?ind=204&cat=4&rgn=30

[77] GA has performed sensitivity analyses on this assumption to understand how it impacts overall individual market enrollment and risk pool mix. GA has modeled 20% to 80% take-up assumptions. Results show that overall individual market membership could decrease by 16,000 or increase by 28,000 with the risk pool mix increasing +/-3%. Sensitivity analyses do not modify the directional results of our analysis.

will be groups that exit the market. We have assumed that the size of the group market will remain stable.

(3) Uninsured and the Individual Market

Individuals who are not eligible for Medicaid and earn less than 400% FPL will be eligible for premium and cost sharing subsidies through the exchange. The premium subsidies and cost sharing limits (defined by actuarial value) are calculated using a sliding scale based on income. GA calculated average household income and corresponding exchange premiums by income category, age category, and self-reported health status for Nevada's eligible uninsured. Table 52 shows the sliding scale of premium contributions and the actuarial value requirements for plans sold through the exchange based on household income. The premium subsidies will be benchmarked to the second lowest costing "Silver" plan design (actuarial value of 0.70) in each rating area. As an example, households with incomes between 138% and 150% FPL would pay approximately $94 per month for health coverage in a plan with an actuarial value of 0.94. The federal government will make payments to cover the cost of the premium and cost sharing subsidies for these members. Note that as household income increases, the monthly premium also increases. For households earning between 350% and 400% FPL, the average monthly premium is $509. Some households may seek exemptions to the individual mandate due to affordability[78].

FPL	% of Income	Avg Monthly Amt Per Household	Actuarial Value
138% to 150%	3.0% - 4.0%	$ 94	0.940
150% to 200%	4.0% - 6.3%	$ 141	0.870
200% to 250%	6.3% - 8.1%	$ 255	0.730
250% to 300%	8.1% - 9.5%	$ 324	0.700
300% to 350%	9.5%	$ 398	0.700
350% to 400%	9.5%	$ 509	0.700

Table 52 – Household Exchange Premium for Nevada Eligible Uninsured

GA then developed a take-up curve for the remaining uninsured (229,000) that varies by household premium, resulting in approximately 106,000 newly insured entering the Individual Market. As exchange premium increases, GA has assumed that the take-up decreases which also indirectly correlates with income and age. This take-up curve was applied to the remaining uninsured. Table 53 shows resulting take-up assumptions and the distribution of the newly insured individual market.

[78] ACA SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE

FPL	Average Take Up	Newly Insured Individual Market
138% to 150%	0.77	7,600
150% to 200%	0.71	32,800
200% to 250%	0.62	26,900
250% to 300%	0.50	16,000
300% to 350%	0.40	9,500
350% to 400%	0.24	3,900
400%+	0.14	9,200
		105,900

Table 53 – Take-Up Assumptions and Distribution of Newly Insured

In addition to the newly insured, we also estimate the number of previously ESI members that would enter the Individual Market and the number of existing Individual Market members that would stay in the Individual Market. We have assumed that the group market remains stable with an influx of new membership into the group market offset by a similar number of individuals exiting the Small Group Market. We assume that some of these individuals exiting the Small Group Market will enroll in the Individual Market.[79] Finally, we estimate that 70% of those individuals that are Medicaid eligible who are currently in the Individual Market will enroll into the state's Medicaid program. Our results show that in CY 2016 the total Individual Market will grow from 87,000 to 225,000[80]. Figure 17 shows that 47% of the new Individual Market were previously uninsured with 34% from the existing Individual Market and 19% from the Group Market.

[79] GA performed sensitivity analysis on the Small Group assumptions, which is explained in Section 6.6
[80] GA performed sensitivity analysis that shows that the Individual Market may grow to between 210,000 and 265,000 members in CY 2016.

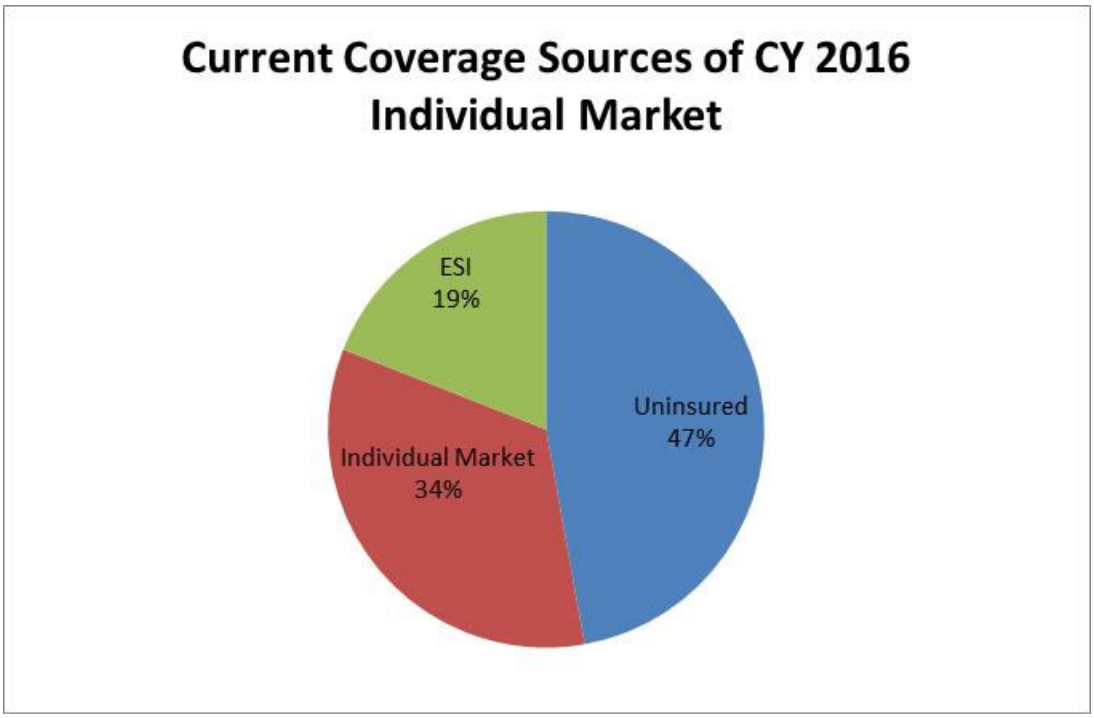

Figure 17 – Coverage Sources of CY 2016 Individual Market

(4) New Individual Market Risk Pool

In addition to estimating the size of the Individual Market, GA has also estimated the relativity morbidity of this new population as compared to the existing Individual Market. This analysis begins by analyzing the three subset populations of the new Individual Market: members who were previously uninsured, members from the existing Individual Market, and members who were previously insured through ESI. Using MEPS, GA calculated health index scores by age category and self-reported health status for the insured population. In addition to health index scores, GA also assumes selection adjustments that vary by take-up. The theory here is that as take-up decreases, selection increases. These selection adjustments were determined by analyzing Nevada's claims distributions for the Individual and Small Group Markets. Table 54 shows our claims distribution analysis. 10% of the most costly individuals cost 6.5 times more than the average. 80% of the most costly individuals cost 25% more than the average. These costs distributions were then smoothed to determine selection adjustments. Using the health index scores and the selection adjustments, GA calculates a morbidity score for the current Individual Market and the new Individual Market. Using this information, we calculate that premiums may increase 8% to 26% with a best estimate of 16%.

Claims Percentile	PMPM Claims Difference from Average
5%	11.39
10%	6.47
20%	3.99
40%	2.17
50%	1.71
80%	1.25

Table 54 – Claims Distribution

6.3. Individual Market Summary of Pricing Changes

There will be many changes in the Individual Market. We have identified premium changes due to the rating limitations, product limitation and risk pool differences. However, there will also be impacts to market premiums due to the reinsurance program and the additional annual fees charged to insurers to offset expected carrier gains.[81]

- **Rating Changes:** The Individual Market will experience significant premium changes as current rating variables are eliminated or limited inside and outside of the exchange. Younger, healthier, male individuals will generally pay higher rates as older and sicker individuals will pay less.

- **Benefit Plan Changes:** With the new essential benefit requirements and actuarial value standards, many benefit plans in the Individual Market will no longer be sold both inside and outside of the exchange. Individual Market premiums could increase approximately 3% as more comprehensive plan designs replace those that are eliminated.

- **Market Changes:** Due to the changing composition of the Individual Market risk pool in CY 2016, premiums could increase an additional 8% to 26% with a best estimate of 16%.

Overall, these changes could cause Individual Market premiums to increase 11% to 30% with a best estimate of 20%, both inside and outside of the exchange in CY 2014 and beyond before consideration of premium subsidies and the ACA risk mitigation programs.

6.4. Individual Market Premium Change Examples

As mentioned previously, there are many changes that will impact premiums for individuals in the Individual Market. There will be rating changes, benefit plan changes,

[81] These were not analyzed for this study and it is possible that by CY 2016, the premium reductions from the Individual Market reinsurance program may mostly be offset by the annual fees charged to insurers.

market changes, and premium tax subsidies. The combined effect will impact each individual differently starting in 2014. We have simulated premium changes for various individuals within the Individual Market. For simplicity, we focused our analysis on single policies only. Table 55 summarizes the results of our simulation. Example 1 is a male between the ages of 30 and 34 who has "good" health status and is currently enrolled in a product with an actuarial value of 0.50. As shown, if this individual earns 138% of the federal poverty level (FPL), he may experience a premium decrease of 63%. This is due to the federal premium tax subsidies available to individuals earning less than or equal to 400% of the federal poverty level. If this same individual's earnings are greater than 400% FPL, he may experience a premium increase of 78%.

					Premium Changes based on Income						
Example	Gender	Age	Health Status	AV	138FPL	200 FPL	250 FPL	300 FPL	350 FPL	400FPL	400+FPL
1	Male	30-34	Good	0.50	-63%	2%	64%	78%	78%	78%	78%
2	Female	30-34	Good	0.50	-73%	-25%	21%	33%	33%	33%	33%
3	Male	30-34	Good	0.70	-74%	-27%	17%	48%	48%	48%	48%
4	Female	30-34	Good	0.70	-81%	-46%	-13%	11%	11%	11%	11%
5	Male	30-34	Poor	0.70	-79%	-41%	-6%	19%	19%	19%	19%
6	Female	30-34	Poor	0.70	-84%	-57%	-31%	-2%	11%	11%	11%
7	Male	40-44	Poor	0.70	-84%	-56%	-29%	-1%	16%	16%	16%
8	Female	40-44	Poor	0.70	-88%	-66%	-46%	-24%	-11%	-10%	-10%
9	Male	60-64	Poor	0.70	-94%	-84%	-74%	-64%	-58%	-52%	-22%
10	Female	60-64	Poor	0.70	-93%	-81%	-69%	-57%	-49%	-42%	-4%

Table 55 – Individual Market CY 2014 Premium Changes for Select Individuals

Table 55 illustrates a general pattern. Individuals earning between 138% and 200% FPL may experience premium changes that range from -94% to +2%. As income increases above 200% FPL, younger individuals may experience premium changes ranging from -13% to 78%. For individuals not eligible for the premium tax subsidy, those above 400% FPL, there will be some premium decreases for older individuals and females. However, there may be premium increases ranging from 11% to 78% for healthier, younger, and/or male demographics. Table 56 shows the current income distribution of the Individual Market. We have estimated that 40% of the market will be eligible for premium tax subsidies with 7% earning between 138% and 200% FPL. 60% of the current market will not be eligible for premium tax subsidies due to their income.

FPL	Current Individual Market
<138%FPL	18%
138% to 150%	2%
150% to 200%	5%
200% to 250%	7%
250% to 300%	12%
300% to 350%	7%
350% to 400%	7%
400%+	42%

Table 56 – 2010 CPS Estimate of Individual Market Membership by Income Level

6.5. Small Group Market

Age & Gender – The ACA elimination of gender rating and 3-to-1 age band on adults will apply in both the Individual and Small Group Markets. All surveyed carriers in the Small Group Market currently use gender as a rating variable and have an age/gender rating band of greater than 3-to-1 on at least some of their coverage tiers. Gorman Actuarial has modeled the impact of the ACA changes on age and gender cohorts within the current Small Group Market. Table 57 shows a summary of the expected range of impact by cohort for the current market population.

Average Impact of Age/Gender Rating Changes						
Age Category	Females-Employee Only	Males- Employee Only	Females-Employee + Child(ren)	Males-Employee + Child(ren)	Female or Male- Couple	Female or Male-Family
0-18						
19-24						
25-29						
30-34						
35-39						
40-44						
45-49						
50-54						
55-59						
60+						

Significant Increases (>15%)
Moderate Increases (5 to 15%)
Minimal Impact (Increase or Decrease < 5%)
Moderate Decreases (5% to 15%)
Significant Decreases (>15%)
Mix of Increases & Decreases

Table 57 – Estimated Small Group Premium Impact of 2014 ACA Age/Gender Rating Reforms[82]

The impact by cohort is directionally similar to the results of the Individual Market for the employee only coverage tiers. Younger males experience the most unfavorable impacts while younger females experience the most favorable impacts. In the Couple and Family coverage tiers, there is a range of results as each carrier rates these coverage tiers differently.

[82] Based on age and gender of subscriber. Only includes data for carriers that rate using subscriber based age/gender factors. Impacts averaged across carriers.

If rates are set at a group level, a young single male employee may not experience a premium increase at all depending on the rest of the employees within the group. Groups with employee populations towards the extremes of the age-gender scale (all male or all female employees, all young adults or all approaching Medicare-eligibility) are likely to experience the most significant premium changes due to these rating changes.

Health Underwriting – In the current Small Group Market, health underwriting is permitted for the purpose of developing a premium rate. Nevada's Small Group regulations currently allow carriers to vary rates +/- 30% around an index rate (1.857-to-1 rate band) for groups with similar characteristics[83], and all carriers use health underwriting in developing Small Group rates.

When health underwriting is eliminated starting in 2014, groups that have had premium surcharges due to unfavorable health status underwriting will experience decreases in their premiums. Similarly, groups that have received discounted premiums due to their preferred health status will likely experience premium increases. Table 58 estimates the premium impact of the elimination of health underwriting. 62% of the market is expected to experience an average 14% increase in their premium as a result of this change, while 38% of the market is expected to experience an average 17% decrease in their premium as a result of this change. Similar to the age/gender rating changes, the overall increases and decreases are expected to offset each other and generate no premium change in total.

Impact of Elimination of Health Underwriting				
	% of Members	% of Groups	Average Premium Impact	Average Age
Premium Increase	62%	60%	14%	34
Premium Decrease	38%	40%	-17%	36

Table 58 – Estimated Small Group Premium Impact of Elimination of Health Underwriting

Group Size – As stated in Section 4.2, Nevada's Small Group regulations allow group size as a rating factor. The average rating band for group size is 1.3-to-1. That is, the highest rate is 30% more than the lowest rate due to group size on average. The ACA does not allow group size as a rating factor in 2014. We modeled the average premium impact of this change by group size, as shown in Table 59. In general, the smallest groups have had the largest premium surcharges, so they will experience the greatest premium reduction when size is no longer an allowable factor. The average group with less than 6 employees will experience a 10% premium reduction. This reduction on the smallest groups is offset by increases on the groups with 6 to 24 employees. The overall increases and decreases from the elimination of group size adjustments are expected to offset each other and generate no premium change in total.

[83] Nevada Revised Statutes, NRS 689C.230.

Impact of Elimination of Group Size Adjustment			
Group Size	% of Members	% of Groups	Average Premium Impact
less than 6	30%	69%	-10%
6 to 9	18%	15%	1%
10 to 15	16%	8%	4%
16 to 24	16%	5%	6%
25 to 50	20%	4%	9%
Total	100%	100%	0%

Table 59 – Estimated Premium Impact of 2014 ACA Group Size Rating Reforms

6.6. Small Group Market Summary of Pricing Changes

- **Rating Changes:** The Small Group Market will experience significant premium changes as current rating variables are eliminated or limited. Younger and healthier groups will generally pay higher rates as older and sicker groups will pay less.

- **Benefit Plan Changes:** With new essential benefit requirements and actuarial value standards, many benefit plans in the Small Group Market will no longer be sold. Small Group premiums may increase approximately 0.5%.

- **Market Changes:** The definition of the Small Group Market will be more standardized across states in CY 2014, with states having to define small group as either 1-to-50 or 1-to-100 employees. Either definition will require a change to the current small group definition of 2-to-50 employees. Groups experiencing unfavorable premium changes may consider dropping coverage or moving coverage to the self-insured market where many of these rating and benefit provisions will not apply. These groups will typically be younger and healthier which could in turn raise premiums in the remaining Small Group Market. Gorman Actuarial has modeled that there will be very little change in the overall group market membership. While there may be some membership disruption with some new group entrants, increased membership in some existing groups and some group terminations, we have assumed that the net effect of these membership migrations to the Small Group Market risk pool is minimal. GA performed a sensitivity analysis on the changing composition of the Small Group Market risk pool. GA assumed that the market will experience a decline in membership representing a healthy morbidity. By reviewing health status score distributions for each group and each carrier in the Small Group Market, GA analyzed claim costs for the 10% and 20% of the market with the lowest morbidity. Results show

that these group's costs are approximately 25% to 30% lower than the average Small Group Market costs. If 10% of members with the lowest morbidity exited the market, premiums may increase 3%. If 20% of members with lowest morbidity exited the market, premiums may increase 7%.

6.7. Small Group Market Premium Change Examples

There are several changes that will impact premiums for groups in the Small Group Market, the largest of which consists of rating changes. The effect of the rating changes will impact each group differently depending on their demographics, group size and health status. We have simulated premium changes for various groups within the Small Group Market. Table 60 summarizes the results of our simulation. Example 1 is a group with five employees, all male between the ages of 30 and 34 with "good" health status and an average actuarial value of 0.75. The estimated premium change as a result of the rating changes discussed previously is 35%. This includes the premium increases due to elimination of health status rating and gender rating partially offset by the elimination of group size rating. As shown, each group is impacted differently depending on their different rating characteristics.

Example	Group Size	Age & Gender	Health Status	Average AV		Premium Change
1	5	30-34 All Males	Good	0.75		35%
2	5	30-34 All Females	Good	0.75		-21%
3	5	30-34 All Females	Poor	0.75		-42%
4	30	Minimal Impact	Good	0.75		27%
5	30	Minimal Impact	Poor	0.75		-8%

Table 60 – Small Group Market CY 2014 Premium Changes for Select Groups

7. Merged Market Analysis

States will be faced with several policy decisions related to merging markets under the ACA. States may at any time elect to merge the Individual and Small Group Market. For CY 2014 and CY 2015 states have the option of defining Small Group as either up to 50 or up to 100 employees. In CY 2016 the definition of Small Group will be defined as up to 100 employees, essentially merging the Small Group and Large Group 51-100 employee markets. Merging market segments requires insurance carriers to pool the claims experience from each market when establishing premium rates for the merged

market. When markets are merged, one market segment may end up subsidizing the other market segment based on their relative claims experience after adjusting for allowable rating adjustments.

7.1. Impact of Merging Markets

The impact of merging markets can vary based on when the merger occurs. In CY 2014 and beyond, the composition of the Individual Market will most likely change. As shown previously, this market will experience significant membership growth. Along with this growth, there may be a change in this market's relative claims costs or relative risk. The Small Group Market and the Large Group 51-100 Markets may also experience membership shifts as groups enter and exit the markets. GA modeled the impact of merging various market segments by using claims, membership, benefit and demographic information primarily from the carrier survey data.

Based on our analysis of the claims experience, demographic distributions, and plan design information (as reported by the carriers), the current morbidity in the Small Group Market is worse than the Individual Market. Currently, carriers are not required to "guarantee issue" of policies in the Individual Market. That is, carriers can deny coverage. As described in Section 4.1, between 10% and 25% of new business applicants were denied coverage each month in CY 2010, and these are presumably applicants with high morbidity. In addition, the Individual Market is health underwritten, so higher premiums are offered to those with higher risk. The Small Group Market is also health underwritten but it is a guaranteed issue market and therefore the Individual Market tends to attract a healthier population as compared to the small group market.

The Individual Market membership is estimated to increase from 87,000 members to approximately 225,000 members and that the new entrants into this market may increase risk pool costs approximately 16%. It is also assumed that there is no significant change to the Small Group or Large Group 51-100 Markets, but given the large growth in the Individual Market, the Individual Market now represents 57% of the combined market segments in CY 2016 as shown in Figure 18.

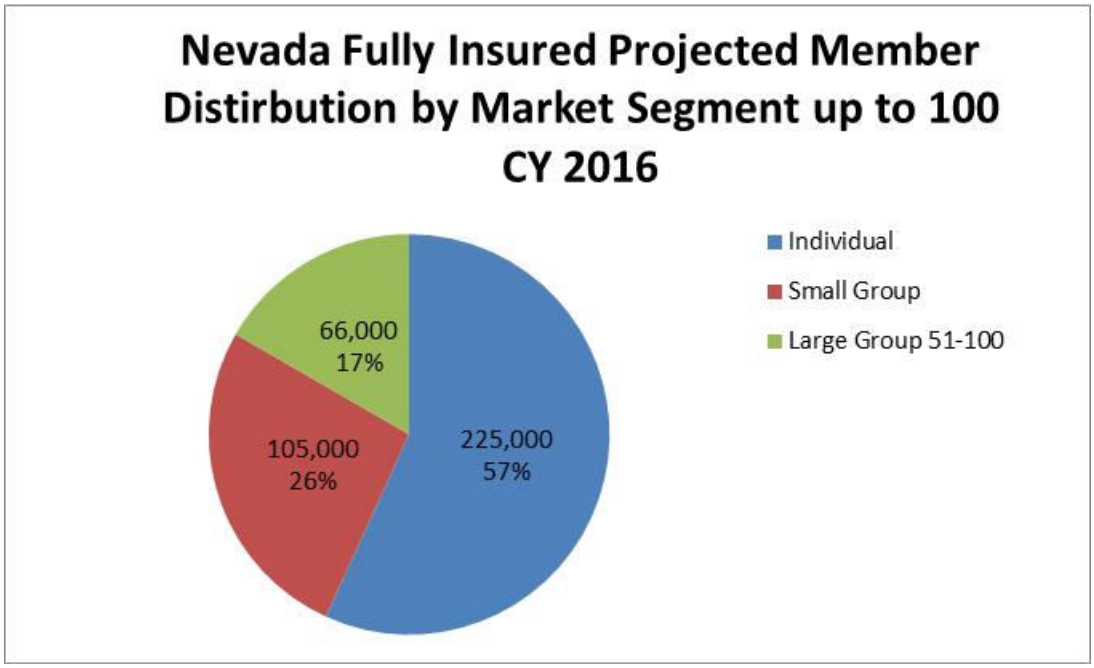

Figure 18 – Fully Insured Member Distribution up to 100 by Market Segment CY 2016

If the state of Nevada were to merge the Individual and Small Group Markets in CY 2016, the Individual Market premiums may experience an increase of 5% to 10% and the Small Group Market premiums may experience a decrease of 10% to 15%. These results reflect the fact that the Individual Market experiences a large membership increase and its relative risk becomes closer to that of the Small Group Market as the Individual Market grows. However, we have modeled that the Individual Market morbidity is still better than Small Group and this market subsidizes the Small Group Market. If the state were to merge the Small Group and Large Group 51-100 Markets, the Small Group Market premiums may experience minimal impact and the Large Group 51-100 Market premiums may experience an increase ranging from 4% to 9%. Since these market segments resemble each other today, the premium changes are relatively small. However, as the 51-100 market shifts to an adjusted community rating formula, there may be an incentive for the younger healthier groups to seek coverage in the self-insured market. This may have an adverse impact on the rating pool. If the state were to merge all three market segments, the Individual Market premiums would experience an increase of 5% to 10%, the Small Group Market premiums would experience a decrease of 10% to 15% and the Large Group 51-100 Market premiums would experience a decrease of 2% to 7%. These results are all as of CY 2016. Table 61 summarizes our results of merging various markets.

	Premium Impact by Market Segment		
	Individual	Small Group	Large Group 51-100
Merging Individual and Small Group	5% to 10%	-10% to -15%	n/a
Merging Small Group and Large Group 51-100	n/a	minimal	4% to 9%
Merging Individual, Small Group and Large Group 51-100	5% to 10%	-10% to -15%	-2% to -7%

Table 61 – Merged Market Results CY 2016

7.2. Advantages and Disadvantages of Merging Individual and Small Group Markets

There are several advantages and disadvantages to merging the Individual and Small Group Markets that the state of Nevada will want to consider when making this decision:

Advantages:

- Creating a larger risk pool will help the spread the risk of high cost claims over a larger population and therefore potentially decrease the volatility in claims and premium of the combined pool.
- The Small Group Market will experience premium decreases, therefore helping to encourage participation and possibly offsetting the likelihood of groups choosing to drop coverage or to self-insure.
- If a defined contribution approach in the SHOP exchange grows, the rating approach in both markets will be the same.

Disadvantages:

- The Individual Market will experience premium increases, which may decrease enrollment.
- There may be significant costs and other administrative challenges to both the state and insurers in combining the markets. For example, insurers may need to make updates to rating systems to support a merged market.
- Given the other changes that will be occurring starting in 2014, like the establishment of an exchange, and given the Individual and Small Group Markets can be merged at any time during or after 2014, it may make sense to hold off on making a decision to merge markets until the post-ACA health care environment can be analyzed further.

7.3. Advantages and Disadvantages of Expanding Small Group Market Definition to 100 Employees Prior to CY 2016

There are several advantages and disadvantage to expanding the Small Group Market definition from 50 to 100 employees prior to CY 2016 which Nevada will want to consider when making this decision.

Advantages

- Creating a larger risk pool will help the spread the risk of high cost claims over a larger population and therefore potentially decrease the volatility in claims and premium of the combined pool.
- Since this has to be done by CY 2016, one could argue it would be better to implement sooner to have time to work out any unforeseen complications.
- Given the numerous changes occurring in CY 2014 it will be better for the market for this to happen simultaneously.

Disadvantages:

- The Large Group 51-100 Market is partially experience rated. The rating methodology will change for the Large Group 51-100 when it merges with Small Group and as a result there may be an additional impact on premiums that is difficult to quantify. There is also the potential to increase administrative costs to the Large Group 51-100 segment when moving to the adjusted community-rated Small Group regulations.
- Merging the Small Group and Large Group 51-100 prior to CY 2016 may encourage some of the 51-100 groups to self-insure and therefore leave the pool. Of course, this might just be a matter of timing since in CY 2016, the markets will merge regardless.
- Since the definition of Small Group has to be expanded by CY 2016, it may make sense to wait until it is a requirement rather than opting to introduce more change and complexity earlier than necessary given everything else that will be happening in CY 2014.

8. Federal Risk Mitigation Programs[84]

The ACA includes three key provisions that are intended to mitigate some of the financial risk that carriers will potentially face as a result of the many changes to market dynamics driven by the law. Through the transition of the next several years, these programs are intended to minimize the impact of adverse selection on carriers and allow them to compete more equitably during the period of market shifts and uncertainty. If these programs are effective, they should decrease the potential risk to specific insurers operating in the Individual and Small Group Market. This section provides a high level summary of the Risk Adjustment, Reinsurance, and Risk Corridor programs in the ACA. Final rules for each program have not been determined at the federal level, but the ACA allows for flexibility to individual states in terms of how the programs are structured and supported. Nevada will likely require more focused operational and actuarial analysis in order to implement and administer these programs at the state level.

[84] The impact of the risk adjustment and transitional reinsurance programs are beyond the scope of this report. However, this information is provided for informational purposes.

8.1. Risk Adjustment

Beginning in 2014, carriers will be restricted to setting rates based primarily on plan design and the age of the covered individuals. While carriers will not be able to deny coverage to anyone seeking insurance, without risk adjustment among carriers, there would be considerable financial incentive for carriers to attempt to enroll more healthy individuals and avoid those with greater health risks. The ACA Risk Adjustment program is designed to discourage carrier "gaming" and create a more equitable market focused on quality and efficiency.

The risk adjustment program will define the relative health risk of a population through a statistical process. Carriers with a population that have a healthier than average health status will be assessed, while carriers with sicker than average health status will be subsidized through those assessments. For example, a carrier with an average health risk score of 0.90 in a market with an overall average health risk score of 1.00 could be assessed 10% of premium to help defray the costs of other carriers in the market covering greater health risks. .

The risk adjustment program will apply to Individual and Small Group Markets inside and outside of the exchange. If a state does not have an exchange, HHS will administer the risk adjustment program for that state. HHS will set the baseline risk adjustment methodology, but each state has the option of establishing a federally-certified alternate methodology in their state.

It is important to note that the risk adjustment mechanism is a transfer of funds from one carrier to another. That is, carriers that receive a risk score greater than 1 will receive funds and carriers that receive a risk score less than 1 will pay into a fund. While individual carriers within each market may adjust their premium accordingly, the premium for the market as a whole will remain unchanged.

8.2. Transitional Reinsurance

The ACA establishes a transitional reinsurance program from 2014 to 2016. This program is designed to mitigate some of the cost uncertainty in the Individual Market that will have many new entrants during this time. The program is temporary (three years) in order to stabilize premiums while carriers develop a better understanding of the costs of the expanded Individual Market.

Both the fully insured and self-insured markets will be assessed to fund a new not-for-profit reinsurance entity that will help pay benefits for higher cost members in non-grandfathered Individual Market plans. HHS will develop the baseline assessment as a percentage of premiums for fully insured carriers, and a percentage of medical claims for self-insured plans. The assessment percentages will decline each successive year of the reinsurance program. The initial CY 2014 federal baseline will target assessments of $10 billion nationally with targets declining to $6 billion in CY 2015, and $4 billion in CY

2016. Nevada's share will be in proportion to its share of premiums and self-insured medical costs nationally.

HHS will also establish the baseline attachment point (the threshold of benefit costs above which a member qualifies for reinsurance), reinsurance cap (the maximum benefit costs covered by reinsurance) and the coinsurance rate (the percentage of costs between the attachment point and cap to be covered by reinsurance). States will have flexibility to modify many of these provisions including higher assessments than the federal baseline.

Assessments will need to cover reinsurance payments plus administrative costs at the state and federal level. If assessments are not enough to cover payments, payments will be reduced pro-rata. States will be required to collect significant data from all payers in the market in order to administer the reinsurance program.

The assessments will increase premiums for the Small Group and Large Group Markets including the self- insured markets. Premiums on average may increase 1.2% in CY 2014 decreasing to 0.4% in CY 2016. The reinsurance program will reduce premiums in the Individual Market ranging from -11.4% in CY 2014 to -1.2% in CY 2016.[85]

8.3. Risk Corridors

The ACA establishes another temporary program from 2014 to 2016 to mitigate cost uncertainty during the developmental period of the new exchanges. The Risk Corridor program will require Qualified Health Plans operating in the exchange to partially share gains and losses among participating plans. This program will be administered by HHS with less flexibility to modify the rules at the state level.

HHS will evaluate a health plan's allowable medical costs compared to target medical costs (premiums less administrative costs). If allowable costs vary by more than 3% from the plan's target costs, then that plan will share a portion of the gain or loss beyond the 3% threshold. Table 62 summarizes the methodology for sharing gains and losses.

Claims as % of Target	Payment Transfer
> 108%	Carrier Receives 2.5% of Target + 80% of Excess Loss Above 108% of Target
103% - 108%	Carrier Received 50% of Excess Loss Above 103% of Target
97% - 103%	No Payments
92% - 97%	Carrier Pays 50% of Excess Gain Below 97% of Target
< 92%	Carrier Pays 2.5% of Target + 80% of Excess Gain Below 92% of Target

Table 62 – Risk Corridor Provisions for Sharing Gains and Losses

[85] Winkleman, Hegemann, Mehmud, "Risk Adjustment and Reinsurance: A Work Plan for State Officials", January 31, 2012. Impacts will vary by issuer and state.

9. Conclusions

As a result of the Medicaid expansion, new premium tax credits, and other programs that go into effect in 2014, Nevada is expected to see the uninsured population in the state decline. Many of these individuals will take advantage of expanded public coverage through Medicaid, or the subsidies available through the exchange.

The private Individual and Small Group Markets will go through considerable change as new rating requirements and benefit plan standards will change the way in which carriers compete in the state. In addition, the new health insurance exchange will create a new channel to research and purchase insurance coverage.

With almost two years since the ACA legislation was passed, there are still many rules and regulations that are not fully defined at the federal level, and other critical decisions remain at the state level. This market study presents a current view of the Nevada health insurance marketplace and analyzes the potential impact of some fundamental ACA-driven market changes. As rules and regulations are promulgated, the projections in this report may need to be revised to reflect the most current marketplace dynamics.

10. Appendix

10.1. Limitations and Data Reliance

Gorman Actuarial prepared this report solely for the use of the state of Nevada. While we understand that this report may be distributed to third parties, Gorman Actuarial assumes no duty or liability to any third parties who receive this information herein. This report should only be distributed in its entirety.

Any user of this report must possess a reasonable level of expertise and understanding of healthcare, health insurance markets and financial modeling so as not to misinterpret the information presented. The report addresses certain provisions of The Patient Protection and Affordable Care Act, but is not intended to act as an official or comprehensive interpretation of the legislation itself.

Analysis in this report was based on data provided by federal and state government authorities and carriers in the Nevada health insurance markets. Gorman Actuarial has not audited this information for accuracy. We have performed a limited review of the data for reasonableness and consistency. If the underlying data is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

The assumptions and projections included in this report are based on our understanding of the ACA and the associated regulations as of the report date. Future regulatory and legislative actions may materially change the impact of the ACA and invalidate certain assumptions or projections presented in this report. Therefore this report should be considered time-sensitive and results may change as new information becomes available.

10.2. Qualifications

This Nevada Health Insurance Market Study report includes results based on actuarial analyses conducted by Bela Gorman and Jenn Smagula, who are members of the American Academy of Actuaries and Fellows of the Society of Actuaries, and meet the qualification standards for performing the actuarial analyses presented in this report.